IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF PENNSYLVANIA

CARISSA PERONIS, et al.,
Plaintiffs
vs.
UNITED STATES OF AMERICA, et al.,
Defendants.

Civil Action No. 16-1389

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Transcript from proceedings on August 30, 2019, United States District Court, Pittsburgh, PA, before Judge Nora Barry Fischer.

APPEARANCES:

For the Plaintiffs:	Harry S. Cohen & Associates, P.C. Douglas L. Price, Esquire Two Chatham Center Suite 985 Pittsburgh, Pennsylvania 15219
For the Defendant USA:	U.S. Attorney's Office Michael Colville, Esquire Philip P. O'Connor, Jr., Esquire U.S. Courthouse 700 Grant Street Pittsburgh, Pennsylvania 15219
For the Hospital Defendants and Dr. Jones	Weber Gallagher Simpson Stapleton Fires & Newby Paula A. Koczan, Esquire 603 Stanwix Street Suite 1450 Pittsburgh, Pennsylvania 15222
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THE COURT: As the court indicated yesterday, after I heard argument on the motion for directed verdict filed by Dr. Jones pursuant to Rule 50, the court wanted the opportunity over the evening to read her notes to this point as well as the rough draft transcript of Dr. Karotkin's testimony.

The court also revisited the exhibits, all of which have been entered into the record, and based on the court's understanding of the law, the motion is denied and here's my reasons:

A motion pursuant to Federal Rule of Civil Procedure 50(a) may be made at any time before the case is submitted to the jury, so says Ponzini, P-O-N-Z-I-N-I, versus Primecare Medical Incorporated, 269 F. Supp. 3rd 444, Middle District 2017, quoting Federal Rule of Civil Procedure 50(a)(2). "If a party has been fully heard on an issue during a jury trial and the court finds that a reasonable jury would not have a legally sufficient evidentiary basis to find for the party on that issue, the court may, A, resolve the issue against the party, and B, grant judgment as a matter of law against the party on a claim or defense that under the controlling law can be maintained or defeated only with a favorable finding on that issue."

I think it's important that the rule contains the word may, which affords the court some discretion. When

deciding a Rule 50(a) motion, the court must, as I said yesterday, view the evidence in the light most favorable to the nonmoving party, giving the nonmoving party the benefit of every fair and reasonable inference. So says Galena versus Leone, 638 F.3d 186 Third Circuit 2011 citing Beck versus City of Pittsburgh 89 F.3d 966, a 1996 decision.

The motion should be granted only if the evidence is not sufficient for a jury reasonably to find viability. To this end, the court must, "Refrain from weighing the evidence determining the credibility of witnesses or substituting its own version of the facts for that of the jury."

So says Eshelman, E-S-H-E-L-M-A-N, versus Agere, A-G-E-R-E, Systems Incorporated, 554 F.3d, 426 Third Circuit 2009, also quoting an earlier Third Circuit decision Marra, M-A-R-R-A, versus Philadelphia Housing Authority, a 2007 Third Circuit decision.

Now, plaintiffs Carissa Peronis individually and as administratrix of the estate of Kendall Peronis along with Matthew Fritzius filed a complaint for professional negligence against Dr. Jones among others on September 8, 2019.

Paragraph 103 of that complaint sets forth a number of allegations relating to issues of Dr. Jones' alleged delay in attending to and treating Kendall Peronis. In that same vein, plaintiffs' counsel, in response to the motion for directed verdict, argues that a question of fact remains as to

whether or not Dr. Jones received and promptly responded to a notification from Heritage Valley Beaver about Kendall Peronis.

Plaintiffs' counsel particularly relies on Joint Exhibit No. 6, medical records from Heritage Valley Beaver in which it is recorded that, "Dr. Jones," and I'm going to put this in brackets, "[was notified at 7:20]."

Additionally, the incident report in Joint Exhibit 15 implies that Dr. Jones was in fact called prior to 7:20. See Joint Exhibit 15 at 1. Specifically it reads, "While in the nursery, infant started having respiratory distress. Residents notified, along with Dr. Jones, regarding infant in nursery with respiratory distress. At 7:20, oxy hood and lab work along with IV placement completed."

Thus there are medical records that are part of the joint exhibits from which a jury can reasonably find Dr. Jones was notified and failed to promptly respond, if the jury finds these records more persuasive than the pager and phone records and the testimony of Dr. Bradley Heiple and Nurse McCrory. After all, the jury is the ultimate finder-of-fact, and again, I would quote to Eshelman.

Now, turning to Dr. Karotkin, who the court finds to be well credentialed and I'd say moderate in his tone. Dr. Karotkin believes that if a baby is at risk, a pediatrician must be present at delivery. His opinion that

this was a delivery that should have had a pediatrician in attendance due to meconium, operative delivery using a vacuum extractor, concern for shoulder dystocia and some delay in getting the baby delivered.

He also noted, although not an expert and not an OB/GYNE, not an expert in fetal strips, but from his knowledge and experience as a board certified pediatrician and neonatologist that the fetal strips weren't entirely reassuring. He had some concern based on a two plus category which is consistent with prior testimony in the plaintiffs' case. He also noted the arrest of descent.

As a consequence, there was the potential or expected use of forceps. In his estimation, a pediatrician should be called in those instances. Relative to same, he specifically noted that the use of a vacuum extractor brings the potential for bruising and bleeding, and we also heard from Matthew Fritzius that the baby did have some misshaping of the baby's head.

He also pointed out that meconium can be a sign of fetal distress, and to that end, in his words, this is the kind of baby that either should have been monitored much more closely in the mother's room with evaluations by either a pediatrician or a nurse to listen to the baby, to observe the baby, do a pulse oximetry, or alternatively, admit the baby directly to the nursery for much closer observation.

He also noted vis-a-vis the call at 7:20 that there was nothing in the record that Dr. Jones did until 8:20. In his words, this is a breach of duty if you don't respond. In fact, he goes on to say that generally, the requirement is you respond within a half hour.

So if the call had been made at 7:20 and received at 7:20, Dr. Jones should have been at the hospital by 7:50. In his estimation starting treatment at 7:50 would have been better than 8:30 or 8:40. However, he does state that Dr. Jones' treatment once she was there was fine. He has no criticism once she arrived. In his words, she did a great job once she was there.

He also goes on to state that in his estimation, the standard of care requires a pediatrician or nurse to evaluate every 15 or 20 minutes despite arguments about bonding. He further opines the delay in treatment increased the harm, because, in his words, this baby was in trouble shortly after birth.

Again, he stated had there been a pediatrician present, the whole process of septic workup would have happened much quicker.

Once again, he readily admits he doesn't know if the call was or wasn't made, but that's what the documents show. If he were sitting on this jury, and he's not, he would tend to believe Jones, but he's not the finder-of-fact.

He also agrees, based on the evidence that he saw, i.e., the telephone and pager records that Dr. Jones was not called. Once again, he had no criticism of Dr. Jones.

So although he has a number of statements very favorable to Dr. Jones' treatment once she is on scene, he does point out that the delay in treatment was potentially causative of harm.

Now, the court would also note that in his opening, Mr. Price did indicate to the court by way of his opening statement that the plaintiffs in this case did not find fault with Dr. Jones' treatment.

Dr. Karotkin has now testified and similarly doesn't find fault, so to that degree, the court would further say that these admissions or concessions by Mr. Price in his opening are binding on the plaintiffs, and to that end, the court would cite to a number of decisions.

There's actually a Supreme Court decision that goes back, I think, to the turn of the 19th century, the 1820s, but more recently, the court would reference Glick Versus White Motor Company, 458 F.2d 1287, a Third Circuit 1972 case, because there, defense counsel made certain concessions during his closing argument about certain of the exhibits which the court found binding.

The court would also cite to a later decision in Pivirotto, P-I-V-I-R-O-T-T-O, versus Innovative Systems,

Incorporated. This is a 1999 decision, and to that end, the footnote reads, "It may be true that an attorney's clear and unambiguous statements of fact made during opening and closing can constitute judicial admissions."

The court would also note a most recent decision out of the Third Circuit, Wolfington, W-O-L-F-I-N-G-T-O-N, versus Reconstructive Orthopedic Associates, 2019 Westlaw 3925948.

So for all of those reasons, the motion is denied. When the jury comes out, Mr. Price, you are going to stand up and formally rest in open court. I'll take you to sidebar. We'll incorporate your prior arguments and I'll incorporate my prior ruling, which has just been read into the record, and then we'll proceed with the remainder of the case.

Now, per caption, Mr. Colville is next, but I understand he's not calling any additional witnesses, unless I'm wrong on that, and so we're going to hear from Ms. Koczan and the hospital defendants; is that right?

MS. KOCZAN: No.

THE COURT: I'm sorry?

MS. KOCZAN: That is not correct. Mr. Colville is calling additional witness, but he will not be here until Tuesday.

THE COURT: Well, I mean, he's not calling any additional witnesses today.

MS. KOCZAN: That is correct, Your Honor.

THE COURT: So I think I'll make some kind of an instruction to that effect that Dr. Wiesenfeld is going to be here on Tuesday and so everybody has agreed that Ms. Koczan can proceed vis-a-vis the various hospital defendants, including the pediatric group, right?

Now, Mr. Price, I heard there was some squabbling between you and Ms. Koczan. You're accusing Ms. Koczan of slow dancing her case.

MR. PRICE: Yes. I apologize if it was a squabble.

THE COURT: I know you two have a history, and in fact, you had a parallel case to this one in front of Judge Cercone which the government settled on behalf of Dr. Lauer and Ms. Koczan went to verdict and won the case.

Go ahead.

MR. PRICE: Your Honor, I believe if you also look at this case, there is reason for me to be suspicion. I've had some issues. I don't want to go into them too deeply, but I think the stipulation that was filed notes a lot of the issues with regard to discovery, with regard to medical records, with regard to production under the federal rules of discovery, but nevertheless, I went back to the office last night and looked at the schedule. So today, we have Dr. Jones will be testifying first.

THE COURT: I thought we had Nurse Ash. Isn't she coming in?

MS. KOCZAN: That's correct. She is.

THE COURT: So we have Ash coming in. That was indicated last night. I read her transcript.

MR. PRICE: Right. Dr. Jones, then Nurse Ash.

MS. KOCZAN: No, Nurse Ash first.

THE COURT: Nurse Ash first and then I understood Dr. Jones and I don't know what follows.

MR. PRICE: Right. As I mentioned with Nurse Ash, the only relevant testimony she has is about the meconium. Now, I know that her testimony can go on for hours about the admission and about hooking her up and doing the initial assessment, but that is not in contention here, so I would say that's irrelevant. The only relevant issue is -- she can talk about some background, but if we spend two hours on every note where she clicked, I believe that's irrelevant.

The only issue in contention is the meconium, and that's the only issue that Nurse Ash can talk to. I know she came back the next morning and saw Carissa after the baby went to the nursery, but again, I can't understand how long her testimony is.

Then we have Dr. Jones, and I know she might be long, but again, it's not -- it should not, the way this case has been going, take up the whole day. On Tuesday, we have Dr. Wiesenfeld and we have Dr. Boyd and Nurse Hackney, and Nurse Hackney was there from 7:00 to 7:30.

On Wednesday, we have two experts, Dr. Coffin and Dr. Ringer. Here's my problem is you advised us all last Friday that today was going to be a full day.

THE COURT: Then I told you that because of speedy trial issues, I scheduled a defendant to come in here at 3:00 this afternoon. I told you that.

I also told you that, in fairness to these jurors and given the Labor Day holiday and given the fact that one or two of these jurors lives a far piece from the City of Pittsburgh, I was going to shut down early today. I also told you that.

I also told you that even if we didn't have witnesses, that we have legal issues to address, i.e. the points for charge, so we're going to fill up the day as much as I can, but I'm expecting we're not going to be here much past 3:00 today. That's what I'm expecting.

MR. PRICE: And I would expect that this afternoon, we could take care of the charge conference.

THE COURT: I'm happy to do that. That's why I'm here.

MR. PRICE: That leaves us with Tuesday, and again, Your Honor, the way I'm looking at it, I don't see a full day.

THE COURT: I don't know. Maybe Dr. Wiesenfeld has a lot to tell us. I don't know.

MR. PRICE: Here is my problem. So Tuesday -- again, I think that Mr. Colville can tell us how long he'll be. My

problem is, Your Honor, as you know, this case was delayed for a year to try to get a good trial date for all of us. A lot of that had to do with Ms. Koczan's schedule.

THE COURT: Right. She tries cases left and right. I recall.

MR. PRICE: So we get here last Friday and you tell us we have Friday, and let's work the schedule. My concern is that we get to Wednesday, we have two experts. I am not long on cross-examination of experts. I don't do that, so I don't know how long we're going to be. Are we going to close on Wednesday afternoon? Is the jury going to go out at 4:00? Are we going to wait until Thursday?

My concern is I put my case in as quickly as I could. I moved experts. I had my clients do half their testimony on one day, and there is an option under the Federal Rules for getting videotape depositions done. It's done all the time. I have to do it if I'm forced to put my case in quickly. You have a chamber rule which says trial engagements must take precedence over any other business.

THE COURT: You would think.

MR. PRICE: The only other business we have this week -- I know we are preparing, but one doctor lives in Philadelphia and there are planes flying across the state every 45 minutes. Another one is up in New Hampshire. There are video conference sites where we can take a deposition via

video conference. We have had one week where Ms. Koczan hasn't explored this issue. She is going to benefit from her delay and from just saying, hey, look, this is when I can do it, when I did everything in my power to get my case in as quickly and as efficiently as I could, and my problem is this jury -- I don't know how attentive they are.

THE COURT: I think they are very attentive. They have been taking copious notes, and I've been watching them, and I've been watching their reactions to the various of the witnesses. They also seem to be a pretty copacetic group. Even happier today because my deputy bought them doughnuts.

MR. PRICE: My only problem is that I know from talking with jurors after cases that the longer a case goes on, the more they forget, and I know my job during closing is to summarize things, but it hurts my case the longer things drag on, and I think if she takes the deposition of one of the experts, you know, it's in the can, and we know we can put it in whenever, and then the other expert comes in Wednesday morning and we do Wednesday closings and we're done.

It is an option that Ms. Koczan hasn't even considered, and she is like no, I don't care, I'm just going to do what I'm doing. That's my problem is. The rules provide for it.

THE COURT: Certainly the rules provide for it. We are looking though at a Labor Day holiday. We are looking at

doctors, and I don't know how many times I've said this, but doctors march to their own beat, and any time you have a doctor in a case, whether it's a treater or whether it's an expert, you have to work with their schedules, and that's just the way of life.

MS. KOCZAN: Your Honor, may I respond to all of what he said? I'd like to begin --

THE COURT: We'll take a little bit, but I'm very conscious it's two minutes to 9:00, so let's hold those thoughts, Ms. Koczan, and I'll let you have your speech, but meanwhile, I forgot one portion of my motion to dismiss ruling, which I think I should also read into the record.

Additionally, the defendants in this case have repeatedly relied upon various hospital policies as part of their defense. These policies have all been admitted into record. Two of these policies contain the signatures of Dr. Jones, as chairman of the Pediatric Department Beaver, and Dr. James Scibilia, as medical director of the nursing department Beaver.

The policies with their signatures relate to the administration of oxygen for newborns and notification of pediatrician/nursery for expected delivery of potentially high risk infant. One of plaintiffs' experts, Dr. Edward Karotkin, was critical of both of these policies and testified that they negatively impacted Kendall Peronis' chance of survival. I

think he was critical of the policies. I don't know of these specific ones. Again, that's a question of fact.

So once again, as I have to say, viewing the evidence in the light most favorable to the nonmoving party, the evidence of professional negligence is not so scant from which a reasonable jury could not find for plaintiffs on the issue of whether Dr. Jones did or didn't breach a duty of care owed to Kendall Peronis.

So as you can see, we worked late into the night on all of these rulings, and we'll put this all in ready form so we can put it on the docket along with our hearing memo.

Now, at this time, I'm going to give all of this to Ms. Starr who is my scrivener, and to that end, you also need all my handwritten notes of what Dr. Karotkin had to say. In case you can't read my handwriting, here's the rough draft transcript.

MS. KOCZAN: Your Honor, I've provided Mr. Price with demonstrative exhibits that show the room where this happened.

THE COURT: That's good. Finally we're getting to see, you know, places. It's always good to see people, places, things. It's always good to have a timeline. It's always good to have a list of characters. So any objection to these demonstratives?

MR. PRICE: Your Honor, my initial objection was I was surprised, but taking a look at it, I don't have an

objection to it. My only concern is that I don't know what the scope and the offer of proof is going to be. If it's just simply these are pictures of the room, I'm fine with it.

THE COURT: Let's hear a proffer.

MS. KOCZAN: Your Honor, nurse -- there was testimony yesterday from Mr. Fritzius about the size of this room, how you could fit three beds, this, that and the other. Nurse Ash is going to talk about -- and also not being able, like a nurse looking in, not being able to see over to the baby, and these photographs clearly show what you can and cannot see, the size of the room, et cetera, so she is going to talk about all that.

THE COURT: Okay. Anything further on that front?

MR. PRICE: Yes. I don't have a problem with her testifying about the size of the room, but I have a problem with her testifying about looking at the room and seeing a baby. She didn't do that. She doesn't know where this baby was. She wasn't the nurse on duty at the time, so she is going to try to establish a fact that she can't establish.

MS. KOCZAN: And, Your Honor, the room is set up such that the bassinet or the warmer is in the same location all the time. It's not any different, and the picture very clearly shows it.

THE COURT: She can say all of that, but she can't say, you know, what was or wasn't in Maria Hendershot or the

unnamed nurse at the nursing station's view was. We all realize it was change of shift. We all realize that it had been a long night. We all realize that Maria Hendershot was winding up and people were coming on and the like, but she is not going to speculate as to what this nurse could or couldn't see.

MS. KOCZAN: All she is going to say is when you open the door, the warmer would have been in front of you. That's it. That's the location.

THE COURT: Okay.

MS. KOCZAN: She is not going to say what Maria could or couldn't see.

THE COURT: She shouldn't because who knows what exactly Maria was or wasn't doing.

Mr. Galovich, before you log those in, it would be nice if I could look at those pictures.

MS. KOCZAN: Your Honor, they are front and back, but it's the same photo. I don't know why they copied that way.

THE COURT: These aren't part of the joint exhibit binder?

MS. KOCZAN: No, they are not. They are just demonstrative.

THE COURT: Number one, who took these pictures? Number two, do they depict the facility as it was at the time of this birth which is now five years ago, almost five years

ago?

MS. KOCZAN: Judy Ash took the pictures.

THE COURT: Why?

MS. KOCZAN: Because I asked her to. And she will testify that she took the pictures and, yes, this is exactly -- this is the room Kendall was -- not Kendall, Carissa and Kendall, and this is what it looked like back then.

THE COURT: Okay. Now, are you going to project these or are you going to pass them?

MS. KOCZAN: No. I'm projecting them. And we can pass them too, Your Honor, if you permit that, but --

THE COURT: I already permitted the original baby pictures to be passed. Things on the screen are not as clear. For example, these pictures of the baby are not as clear on the screen as they are in this fashion. Okay.

So, Mr. Galovich, the court has now had an opportunity to review Valley/Jones demonstrative exhibits which is a series of, altogether, six photographs and the court has heard the proffer. I don't see anything objectionable in the proffer so I think we are finally ready to go.

MS. KOCZAN: This is another extra copy.

THE COURT: An extra copy.

MS. KOCZAN: Right. In the event you want to -- that

we can pass them.

THE COURT: Then Mr. Galovich will do the passing.

MR. PRICE: Your Honor, one quick issue, before I close, I wanted to introduce as Plaintiffs' Exhibits 1, 2 and 3 the actual tables from Dr. Kenkel's testimony where they were projected. I submitted them to Mr. Galovich as demonstrative exhibits, but I would like to introduce them as the Plaintiffs' Exhibits 1, 2 and 3.

THE COURT: Any objection from the defense? Have you seen these tables? They are part of the report.

MR. PRICE: These are just copies of the report.

THE COURT: They are the tables only.

MS. KOCZAN: It is demonstrative.

MR. PRICE: No.

THE COURT: They are tables only, correct?

MR. PRICE: Correct.

THE COURT: Let me see them. Are these the U.S. government tables?

MR. PRICE: No, no.

THE COURT: These are your demonstrative exhibits.

MR. PRICE: Correct.

MS. KOCZAN: These are not part of the joint.

THE COURT: They are not part of the joint exhibit binder, one.

Number two, the data contained herein comes from

Dr. Kenkel's report. They are not the government tables. In my estimation, Mr. Price, these are demonstrative, so to that end, Mr. Galovich, I think -- do you already have a set of these?

THE CLERK: Yes. I would have them in here, judge.

THE COURT: They are demonstrative. They can be used in your closing argument but they are not going to go out to the jury, per se.

MR. PRICE: Okay.

THE COURT: Anything else now? It's 9:08. Our jurors have been here bright and early.

MS. KOCZAN: Can I get Judy to bring her in?

THE COURT: No, because the first thing that happens is he has to rest. Then you can go get Nurse Ash. Mr. Galovich, if you'll be so kind.

(Jury present.)

THE COURT: Good morning, ladies and gentlemen of the jury. I trust you had safe travels in on another beautiful day as we head into Labor Day, and I hope Mr. Galovich didn't ruin your diets by bringing you in doughnuts today, so I hope you enjoyed. I'm sure Mr. Galovich hopes you enjoyed.

This is one reason why when, after trials are over, everyone writes me notes how much they appreciate Mr. Galovich and his professionalism and how he treats our jurors. So for that, the court thanks him.

At this time, Mr. Price, where are you vis-a-vis the plaintiffs' case?

MR. PRICE: We have completed the plaintiffs' case.

THE COURT: So the plaintiff is now resting, correct?

MR. PRICE: Right.

THE COURT: I'm going to ask counsel to come to sidebar.

(At sidebar.)

THE COURT: And at this time, the court acknowledges the motion for directed verdict filed by Dr. Jones. The court incorporates yesterday's arguments, the court further incorporates its earlier ruling on the record. That motion is denied, so we're going to continue with this case, and as I indicated, we'll make a brief statement to the jury that, although Mr. Colville is next on the caption, his next witness will appear on Tuesday. Hence, Ms. Koczan has agreed to proceed.

(In open court.)

THE COURT: Ladies and gentlemen of the jury, although, as you know from having heard the caption in the case, the United States is the next defendant. The next witness the United States would like to call is not available until Tuesday morning, so Ms. Koczan, who represents the remainder of the defendants, has agreed to proceed and she is now going to be calling witnesses.

Ms. Koczan?

MS. KOCZAN: Yes, Your Honor. Judy Ash and I'll go get her.

THE COURT: All right. Thank you.

Ms. Ash, please approach Mr. Galovich, my deputy, so you can be sworn.

THE CLERK: Please state and spell your name for the record.

THE WITNESS: Judith Ash, A-S-H.

(Witness sworn.)

THE COURT: Thank you, Mr. Galovich. Ms. Ash, once you get to the witness stand. Watch your step. It's a little uneven. Please have a seat and arrange the microphone so you are speaking into it. It adjusts. It can be moved back and forth. There's also water there in case you need it. Ms. Koczan, you may proceed.

MS. KOCZAN: Thank you, Your Honor.

JUDITH ASH, a witness herein, having been first duly sworn, was examined and testified as follows:

DIRECT EXAMINATION

BY MS. KOCZAN:

Q. Good morning.

A. Good morning.

Q. Can you please state your full name for the jury?

A. Judith Ann Ash.

Q. And Judy, where do you live?
A. In Calcutta, Ohio.
Q. What is your occupation?
A. I'm a registered nurse.
Q. And where do you work currently?
A. I work at the Beaver Medical Center Heritage Valley Beaver Medical Center.
Q. Were you employed by the Beaver Medical Center back in 2014 at the time of the events that we are going to be talking about here today?
A. Correct.
Q. Can you tell the jury a little bit about your education, where you went to high school, nursing school, et cetera?
A. I graduated from Beaver Local High School in Lisbon, Ohio in 1984, went on to college, quit college.

I worked for an attorney for eight years, went back to college eight years later and finished my nursing degree in 1995.

I worked for East Liverpool City Hospital as a med-surg nurse from '95 to '97. I then went up to OB, transferred to OB. I did maternity, nursery and labor and delivery until 2000.

I became employed at the Heritage Valley in 1999, strictly labor and delivery. I like labor and delivery. So I went to work there mainly and have worked there ever since.

Q. And when you came to the labor and delivery room and became employed at Heritage Valley, did you receive some sort of orientation to the labor and delivery unit?
A. Correct. You get orientation. I was labor and delivery trained six months at East Liverpool City Hospital, so I came there with that on my -- since '97, so I had two years labor room experience, so I had I do believe between six and eight weeks of training.
Q. Did that training include the interpretation of fetal monitoring strips?
A. Correct.
Q. Did the training include neonatal resuscitation?
A. Correct.
Q. As part of that training and part of your job responsibility there, are you required to be -- is it NRP certified?
A. Correct.
Q. And can you tell the jury what is that certification?
A. You have to take a neonatal resuscitation class where you have to go through classes and hours of lectures and stuff where they teach you the correct responsibilities where then you take tests to make sure that you still are able to perform your job.
Q. And as part of that orientation, did you also have to learn the policies and procedures of the labor and delivery

suite?
A. Correct.
Q. Now, the jury has heard that some of the maternity nurses work labor and delivery, nursery and also in the postpartum unit. Are you one of those, or are you at one area?
A. No. If you are hired now at the hospital, you have to work all three areas, maternity, nursery and labor room. I was hired in before they did that. Strictly they had all three places they could work. I do have to work labor and delivery, and then I have to go to maternity like once a month and if there's call-offs or if the help is needed.
Q. When you say maternity, what are you talking about?
A. That's following the delivery, they go then to postpartum that takes care of them. After we recover them following delivery, then they go to postpartum until discharge.
Q. We heard some testimony from plaintiffs yesterday about Carissa going to the recovery room. Is there actually a recovery room, or is that a labor room?
A. You recover in the room you deliver in.
Q. Where you go next is the maternity?
A. Maternity postpartum.
Q. Or what I call postpartum; is that correct?
A. Correct.
Q. Can you give the jury some idea of what your responsibilities are as a labor and delivery nurse taking care

of patients such as Carissa?
A. When the patient comes in, we determine if they are in labor or whatever their complaints can be. Every patient is different. We determine if they are in labor, and if they are not in labor, we call the doctor and get orders, and then we admit them and start an IV, do blood work and follow their labor progress throughout their labor.
Q. Okay. When you say follow their labor progress, what do you mean by that? What do you do?
A. Every patient is different of what my duties can entail. From changing -- depending on the fetal heart tones, you have to change positions, increase IV fluids, put a tube on them. They can change periodically through the case depending on what the case might entail.
Q. As part of your responsibilities, are you responsible for monitoring the fetal heart tones and fetal heart monitor?
A. I'm responsible for monitoring the mother and the baby.
Q. And as part of that -- we saw some tracings before. Is that part of what your responsibility is to review those tracings?
A. Correct.
Q. To note changes, alert the physician, that type of thing?
A. Yeah. We have continuous monitoring systems throughout wherever. You always have to have someone. If you have to use the facilities or take a break, whatever, there has -- we

usually say watch my strip, and if something goes on, somebody is there watching it.

Q. And in addition to watching the strip and monitoring that, what do you do for the patient? What are your responsibilities as far as monitoring the patient, being the mother at that point?

A. You want to always monitor her vital signs. You want to make sure she is comfortable, that she has what she wants. This is the best time of their life. They are having a baby.

You want to do whatever you can to make sure this is a good time for them, so you want to make sure she is comfortable. You want to make sure -- unfortunately, I can't offer a lot, ice chips and popsicles, that's about it, but you try to do whatever you can to make sure that they are at their best and they are comfortable, so you want to make sure that their pain choices, make sure you facilitate that and help them through the process the best you can.

Q. And once the labor has progressed such that it's time to push, are you there with them at that point too?

A. Correct.

Q. What do you do at that stage?

A. Then you instruct them on the pushing, set them up for the pushing, and you can push with the patient, which can take from no time to a lot of time.

Q. And you say you push with the patient, what does that

mean?
A. You instruct them on how to push with the patient, to have them -- help assist them with the pushing of the baby out.
Q. Is it primarily instructions?
A. Yes. It's instructions and making sure, and depending on how the baby is and the position of the baby coming down, sometimes we will have to change positions. There's a lot of different ways we can do that. It can go on for hours.
Q. When the baby is actually being delivered, what is your responsibility at that point?
A. Assisting in any way, any assistance that might be needed for a delivery, being there to assist the doctor.
Q. And then once the baby is actually delivered, what is it you are required to do?
A. To take care of the baby.
Q. And what does that include?
A. Then you are drying it off, you are making sure the respirations are okay, the muscle tone is okay, the respirations are okay and you just assess the baby.
Q. And then after the baby is assessed and the baby is stabile, what responsibilities do you have with regard to the mom at that point?
A. You want to check her fundus, you want to check the bleeding, you want to make sure IV access, you have to change her medications that she gets after delivery. So we have to

change medications on her and give her medications, and if she is bleeding, it depends. Every situation is different.

Q. And is it unusual that you will start being the initial nurse and then someone takes over for you and actually the baby may be delivered on somebody else's shift? Is that at all unusual?

A. No, that's not unusual at all.

Q. So what you've described is what all the labor and delivery room nurses do; is that correct?

A. Usually, yes.

Q. And in terms of checking the mom after delivery, what is the requirement? How frequently do you have to check them?

A. Every 15 minutes following delivery.

Q. For how long?

A. For an hour. Then it's a half hour times two. Then every hour times four.

Q. And that's the policy and procedure at Heritage Valley; is that correct?

A. Correct, yes.

Q. What I'd like to do now is -- before I go further though, after you've done that and mom is stable and has been recovered, do you transition them to the postpartum unit?

A. Correct.

Q. How do you do that?

A. Via wheelchair. Is that what you mean?

Q. Just wheel them down the hall?
A. Just wheel them down the hall.
Q. With regard to the baby, at what time do they have to be transitioned into the nursery?
A. Are you talking about at that time in 2014?
Q. In 2014, that's what I'm talking about.
A. Within two hours, the nursery likes to have the baby to give the erythromycin, the antibiotic ointment and the vitamin K blood clotting factor shot, and then we transfer to the nursery.
Q. I want to talk about your care of Carissa Peronis. First and foremost, do you remember Carissa?
A. I probably couldn't pick her out in the crowd, no.
Q. She is sitting back there (indicating).
A. Yes, okay. I recognize. She was a very sweet, nice girl, cute, very.
THE COURT: Let the record reflect that Ms. Koczan has pointed to Ms. Peronis who is seated in the galley.
A. I would agree. If she wouldn't have said that, but now I'm looking at her, she is still a cute girl.
Q. How did you first become involved in Carissa's care on October 12 of 2014?
A. She came in -- as I do recall, she came in with complaints of ruptured membranes and mild labor.
Q. I have a document I'm going to show. It's document No.

918. I believe this is your first note. If we can just look at that. You've got the screen in front of you.

Is that your first note for when, if we can scroll down, when Carissa first came in?

A. Yes.

Q. What shift were you working that day?

A. 7:00A to 7:00P.

Q. Were you the nurse, according to this, who admitted her to the labor and delivery room?

A. Correct.

Q. And before we go any further, I want to ask you and show you some pictures. We have marked and we'll put this up on the screen, this is Dr. Jones and Valley Medical room No. 1.

Let me just ask you this: First and foremost, where did this picture come from?

A. It's labor room 6.

Q. Excuse me. I have it marked here as room 1 for demonstrative purposes for the court.

A. It is labor room 6.

Q. Is this the labor room Carissa was in?

A. Yes.

Q. Where did this picture come from?

A. I took it.

Q. And can you explain to the jury what it is that you are seeing here?

A. I apologize because I had a patient yesterday, so it was right after she had got out of the room, I took it. That's a laboring bed. Beside the laboring bed is our monitor that monitors the patient and the fetal heart tones.

Q. The monitor, you are talking about on the left to the left of the bed there?

A. Yes.

Q. That's the fetal heart monitor that we have been hearing about?

A. Yeah, that's below.

Q. And is this room as it's depicted in this photograph exactly the same as it was back in 2014?

A. Yes. It's the same as it's been since I came in 1999.

THE COURT: I'm sorry. Keep your voice up.

THE WITNESS: It's the same as since I've been there since 1999. That room has not changed.

THE COURT: Thank you.

Q. So if you could just again explain. To the left, we see the door and where does that door lead?

A. That leads out to the main nurse station.

Q. And room number 6, labor room No. 6, where is it in conjunction to the nurses' station?

A. You make -- I'm horrible about yardage. As soon as you walk out the door, the nurses' station is right next to it.

Q. Right in front of it?

A. Right. It's close.
Q. So I see on the bottom of that bed, there appears to be -- is that stirrups, for lack of a better word?
A. Yes.
Q. So when mom begins to push --
A. You lower the bottom of the bed. You raise her legs up and put them up in the stirrups. There will be handles on each side of the bed that come up for her to grab on to push with.
Q. I think we can see those on the bottom on the left there; is that correct?
A. I don't know if you can see it or not, because they tuck underneath the bed because they flip down and flip up.
Q. I want to show you another picture here, and this is room 2 -- again, this is labor room 6. I have it marked as room 2. If you can explain what this picture depicts.
A. That just shows the chair for any member of the family to stay in and the cupboards for our supplies, and then you can see the restroom in the far left corner.
Q. Up there on the corner, that's the restroom up there?
A. Correct.
Q. And then let's take a look at the next one that you took, and this is -- we've labeled it for demonstrative purposes as room document 3, but again this is room 6 of the labor and delivery, correct?

A. Correct.
Q. So is this the view that you would have walking through the door into the room?
A. Correct, because the bed is on the left and the isolette is on the right, yes.
Q. Is that isolette always in that position?
A. Yeah, always.
Q. So if you were to walk in the room, the isolette would be kind of directly in front of you?
A. Correct.
Q. And then mom would be over there to the left?
A. To the left.
Q. The chair there?
A. Right.
Q. These rooms don't look particularly large. Do you know what the dimensions are?
A. I don't know off the top of my head, no.
Q. So was this then the room that Carissa was admitted to --
A. Yes.
Q. -- back on October 12 of 2014?
A. Yes.
Q. Now, going back to your initial notes from that day, and let's put that back up, 918, and if you can just explain to us what you did initially, and we'll move through this pretty quickly.

A. Okay. That just shows -- explains her pain assessment. She is leaking. She went to the bathroom. She complains of pain. She rates it a seven. She is having contractions.
Q. Did you obtain an initial set of vitals on Carissa?
A. Correct.
Q. Document 890. And is this the initial vital signs you obtained?
A. Correct.
Q. And what was her temperature that day?
A. 98.4.
Q. Is that considered to be normal?
A. Yes.
Q. Every other vital within normal range at that point?
A. Everything.
Q. And when you first get her into the room, what is it that you do for her?
A. I hook her -- I explain the fetal monitoring system to her and hook her up on the monitor.
Q. And at some point after she was admitted, did you also do a test to make a determination as to whether her water had actually broken?
A. Correct. I did an AmniSure.
Q. We heard about that before, the AmniSure test. How is that performed?
A. I stick a Q-tip into her vagina and I swirl it for a

minute, and then I swirl it in a test tube for a minute, and I put a test strip in and let it sit for ten minutes. If it comes up two lines, it's positive. If it comes up one line, it's negative.

Q. We've heard some testimony yesterday that you didn't know how to use the AmniSure and had to read directions. Do you have any recollection of that being the case?

MR. PRICE: Objection, Your Honor.

THE COURT: Sustained.

A. Can I answer it?

THE COURT: No. Ms. Koczan can rephrase the question.

Q. Do you have any recollection of, back in your time that you were caring with Carissa and in Carissa's case, of having any difficulty performing that AmniSure?

A. I don't. I might have had to read the instructions because that was maybe a new test at the time to perform along with the Nitrazine that we also use to -- that's supposed to be more accurate. Maybe I had to see how long I had to swirl it, because if you don't use it every day, then you would have to see how long it had to sit in before the test could be run, but it wasn't a hard test to perform to not be able to do.

THE COURT: For the benefit of the court reporter, can you spell Nitrazine?

THE WITNESS: You are asking a person who can't

spell.

MS. KOCZAN: N-I-T-R-A-Z-I-N-E.

THE COURT: Thank you.

Q. After you got Carissa in there, put her on the fetal monitoring strip, do you have any recollection of there being any issues with the fetal monitoring strip?

A. No.

Q. Anything concerning on the fetal monitoring strip?

A. No.

Q. And let's go to your next note then and that's 918. And this one is at 1425, and again, let's just look at that fetal monitoring strip section there down below.

Can you tell the jury, under that, it says fetal heart rate. It's 130. Is that unusual?

A. No.

Q. What is the normal fetal heart rate?

A. Anywhere between 110 and 160.

Q. And I think that's right below there, it talks about that?

A. Correct.

Q. And below there, you mention that some of the things that you saw there were accelerations. What are they?

A. That shows fetal well-being, and acceleration is 15 beats by 15. The baseline of the fetal heart tones, which I have as 130. If you have accelerations, the heart rate will raise 15 beats above 130 for 15 seconds and then come back down to

baseline.
Q. I see you did -- did you do a vaginal exam at that point?
A. Correct.
Q. And how far dilated was she at that point?
A. Three centimeters.
Q. And it says that she is 80 percent cervically effaced. What does that mean?
A. Effacement. Effacement is of the cervix. The cervix starts out thick, and as they are laboring, it thins, and usually it will thin first and then open.
Q. You mentioned before that she was leaking. Do you have any recollection of the color of what was leaking at that point?
A. No.
Q. And is there any document there at that point about that?
A. The color, no.
Q. At this point, is Dr. Dumpe in there?
A. No.
Q. Have you called him yet?
A. Probably not. I'm running the test to determine. Not until I have an answer whether she is or not. I don't need him there until I determine whether she is ruptured or not.
Q. At this point in time, was the AmniSure done yet or not?
A. I'm not sure where I noted the AmniSure was done at. Was it up above?

Q. Put 918 up. I think it may be there.
A. Once I do it, it takes ten minutes to do.
Q. We looked at 919. Let's look at 920. It may be on that page. If you want to scroll down through that.
A. I had the spontaneous ruptured membrane status so I must have done AmniSure to determine that she was.
Q. And you say here that the fluid testing was positive. I see the AmniSure right there.
A. Correct. There you go. There's the lot number and everything, and it was positive. That's where it says.
Q. At this point in time, have you determined that she is in labor or not?
A. Well, I'm probably still watching her cervix to see if her cervix changes, and that's how you determine if they are in labor or not, or if they rupture membranes, then we would keep them.
Q. If we scroll down a little further and go to 921, keep scrolling, and I see here that as part of that note, you have some documentation that you called Dr. Dumpe with report and orders received to admit.
If you would explain to the jury what's that about.
A. Like I said, if she comes in to labor or rupture membranes, it's our job to figure out if she is in labor or if her membranes are ruptured, and we call a doctor with the report of what's going on, fetal heart tones, what they look

like and what I discovered, and then apparently he's giving me the orders to go ahead and admit.

Q. And let's go to your next note there, which is 922. If we can go through that, scroll down through that. I see a note here at 1515 which would be what 5:15?

A. 3:15.

Q. I got my military time wrong there. Again, fetal heart tones, were they within the normal range at that point?

A. Correct.

Q. Everything looked okay?

A. Correct.

Q. And if we could go to 923 and 3:26, anything unusual going on then?

A. I'm sorry. It's hard for me to read. No. Everything looks good.

Q. Everything looks good?

A. Yes.

THE COURT: Once again, keep your voice up a little bit.

THE WITNESS: I apologize.

THE COURT: I know you are reading and looking but we have eight very interested people over there that need to hear what you say.

THE WITNESS: I apologize. I'll try.

Q. At that point, there's a note here now from 1604 which

would be 4:04; is that correct?
A. Correct.
Q. And at that point, again, fetal heart tones were 135?
A. Right.
Q. Again, is that within the normal range?
A. Correct.
Q. And let's go to 924, which is your next note. I think this is a continuation.
A. Yes. Accelerations, the baby is still accelerating. I did the vag exam, she is still 3 and 80.
Q. What does that tell us at that point?
A. Her cervix hasn't changed, so she isn't changing her cervix, but she is ruptured by the AmniSure that shows us that it's ruptured, and she is uncomfortable.
Q. Let's scroll down a little bit further. There's a note here of you contacting Dr. Dumpe. What was the purpose of that contact at that point?
A. Dr. Dumpe called in and notified the patient -- I guess she was comfortable. I rated her pain. I have five. Okay. Comfortable with contractions not needing an epidural yet, but he says he'll come in if I need him before.
Q. Let's scroll to the next page which is 925. If you can explain to the jury what's going on at that point?
A. Heart tones look good, normal range, contractions, everything looks the same. Still having accelerations 15 by

15.

Q. Those accelerations are a good thing; is that correct?

A. Correct, a good thing.

Q. Let's go to the next note then, which is -- this is the 5:15 note?

A. No. 4:45.

Q. 6:45, I'm looking at the 5:15.

A. You highlighted the wrong one.

Q. If you tell us what's going on at that time. Anything changing at that point?

A. Contractions two to four minutes apart, lasting 50 to 60 seconds and they palpate moderate.

Q. What does that all mean?

A. That you palpate her contractions to see the intensity.

Q. So you are actually helping her abdomen?

A. Correct. You do that periodically, not consistently, because if she is changing cervix or if she is staying, it's not like I'm rolling her out anymore, so the need to palpate every single contraction is not needed. We are keeping her. We're not sending her home.

Q. Let's look at the next one. I see one here from 1750. You mention that a fluid bolus is given. What is the purpose of that?

A. I do believe for the epidural. Dr. Dumpe at nurses' station re -- now that the doctor is there, I'm able to call

and get her epidural because she was uncomfortable enough.
Q. And the epidural is what? The OB anesthetic that women get?
A. Correct.
Q. And is this when the epidural then was started?
A. At 1724, the -- you always give a patient a fluid bolus because the epidural can drop their blood pressure, so you increase the body fluids to compensate for that decrease in blood pressure, and I told her, yeah, she is setting up and she has continuous blood pressure readings every five minutes and she is instructed not to get out of bed.
Q. Let's look at the next couple of notes. The next one here is from 1740. Is this just documentation of you continuing to monitor the fetal heart tones?
A. Correct.
Q. And her?
A. Correct.
Q. Let's go to the next one. This is 1745, and what's going on at that time?
A. The epidural infusion is going at a rate of 12, so the pump has been started, and it just talks about her degree of block with the epidural, that she is able to move her knees and flex at the feet. And she has -- she is numb to like the lower rib cage. She is awake, alert and there's no -- no necessary action needed.

Q. So up to this point in time, this brings us up to 6:00. Is there anything unusual going on with either Carissa or the baby by way of the fetal monitoring strips?

A. Nothing.

Q. Let's look at the 6:00 note and if you can tell us what's going on at that time?

A. Everything is still -- still looks the same. Baby looks good. 135 with accelerations 15 by 15. Just complaints of pain or discomfort, and the alleviating factor, she did get an epidural. It's just saying, with that pain, she got an epidural.

Q. Let's look at the 1830 note. This is 6:00 p.m. Again, the first part of this note deals with the fetal heart monitor; is that correct?

A. The TOCO, again, and the contractions.

Q. The TOCO, that is the fetal heart monitor?

A. The TOCO measures contractions, and the fetal monitor is -- the external fetal monitor measures -- it's an ultrasound. It picks up the heart rate.

Q. So let's go to the next page, which would be 930. Tell us what's going on there in terms of the baby's heart rate.

A. 135, normal heart rate, accelerations 15 by 15. I did a vag exam.

Q. We see Dr. Dumpe is in, or did you do the vag exam?

A. He did it.

Q. Dr. Dumpe?
A. Yes, Dr. Dumpe.
Q. And how far along was she at that point?
A. She remained three CMs, 90 percent effaced, minus one station.
Q. Had she progressed at that point?
A. She thinned out a little. It's still my assessment.
Q. Under vaginal bleeding, you have bloody show. What does that mean?
A. When the cervix either thins or dilates, it can bleed and it sheds off blood.
Q. So that's what was going on at that time?
A. Yes. It usually shows progress, yes, as long as it's not a lot of bleeding. That's all normal.
Q. Then the next thing below that, I see AROM of forebag, artificial rupture of membranes forebag?
A. Correct.
Q. We heard that her water had broken before and now there's the artificial rupture of membranes of the forebag. What is the difference there?
A. Sometimes people can have a high leak and they can leak amniotic fluid and it can test positive when we run our test, but then later on, they'll have a forebag that will be there still. It's another -- there's another amniotic sac that's there, so they might be leaking high up and it's not the

full -- how people say they have a gush of fluid and all this fluid comes out. Sometimes it's a high leak and they trickle a little bit, but it's not like the big gush, but then this big forebag will form. We call it a forebag and he broke that.

Q. Let's go to the next note then. I want to ask you about that. This is at 6:30; is that correct?

A. Correct.

Q. Why don't you read to the jury what your note is and explain that.

A. Dr. Dumpe called and notified, a sterile vag exam, forebag felt, Dr. Dumpe at bedside to break the forebag so vag exam three plus ruptured light green-colored fluid.

Q. I want to ask you about that. The light green-colored fluid, what is that? What was that?

A. You just describe what you see when he breaks the water. Just fluid that came out that was colored light green.

Q. Okay. And the jury has seen before Dr. Dumpe had a series of bottles one with clear fluid, light green, darker green, et cetera, and the second one was Gatorade, a light green.

Can you give us some idea of what you mean by light green?

MR. PRICE: Objection, Your Honor. If we're going to talk about --

THE COURT: We should use the demonstrative.

MS. KOCZAN: I'll be happy to use that.

THE COURT: Picture is worth a thousand words.

MS. KOCZAN: There it is.

THE COURT: This was a demonstrative that was used previously, so your attention is being called to it, Ms. Ash.

Q. Looking at those bottles of Gatorade and then something else at the end there, what was the fluid at this time? What did it look like?

A. Like the second one in, that yellowish green looking.

Q. That's what it looked like at the time?

A. Correct.

Q. We can put that down then. So that light green fluid, where did it leak? Was it on to the pad?

A. I usually put a towel -- when they are going to break the water, I put a towel underneath. There's a big green Chucks that's there. It's a green thick pad underneath to catch any fluid or anything that leaks out of the patient. I put a towel usually right underneath the patient which is easier to change a towel than the big green, and once they get an epidural, to have them raise up to change, it is harder, so I usually put a towel right under it, and whenever they do rupture, it's easier to see the fluids that would come out.

Q. During the course of your career, have you seen meconium fluid?

A. Yes.

Q. Have you seen clear meconium fluid?

A. Clear?
Q. Yes.
A. Clear, I mean, like --
Q. Thin meconium fluid?
A. Thin, yes.
Q. And we've heard some different terms here, thin, moderate, heavy. How would you describe this?
A. It was thin.
Q. And what's the difference between thin and moderate?
A. Moderate has more particulate in it. It has more of the forming of the stool. It's a thicker consistency.
Q. And can you tell the difference between thin or when there's particulate in there?
A. Yes.
Q. You can see that?
A. Yes.
Q. You don't have to put that under a microscope to see?
A. Not that I've ever had to, no.
Q. This was thin?
A. Correct.
Q. Now, let's go to your next note, which I believe is 931. Go to the next one, 932. I believe this is -- would this be your last note. Actually Nurse Hendershot took over at that point; is that correct?
A. Correct.

Q. So that one that we looked at would have been your last note; is that accurate?
A. Correct.
Q. At any time while you were there with Carissa that day, was there anything abnormal on the fetal monitoring strip?
A. Absolutely not.
Q. Was there anything abnormal in terms of Carissa's -- your examination of Carissa?
A. No.
Q. Or her vital signs?
A. No.
Q. Now, Maria came on at 7:00 p.m. Were you the one who assigned Maria to take care of Carissa?
A. Yes.
Q. And why did you do that?
A. Because she was a sweet girl. That's a dream when you come in and get a sweet couple. They were a sweet couple. I liked them. Everything was picture perfect with her strip.

Maria is an awesome nurse, and I thought what better way. I love Maria, so I gave her her. I mean, unfortunately -- you love when people give you nice patients like that.

Q. And after you left that day, did you hear anything about Carissa or the baby after that?
A. I came in the next morning. I was scheduled the next morning.

Q. When you came in, did you hear that the baby had been delivered?
A. Yes.
Q. At that point, was there anything going on with the baby?
A. At that point, no.
Q. And did you at some point during the day receive information about what happened with the baby?
A. I heard that it was being transferred.
Q. Did you later hear what happened to the baby?
A. I had walked over to the nursery to just check on the baby to see how the baby was doing, yeah. That's when the code was happening.
Q. And were you surprised to see what was going on?
A. I've never seen anything like that in my whole career, never.

MS. KOCZAN: Thank you. Those are all the questions I have.

THE COURT: Cross-examination, Mr. Colville.

CROSS-EXAMINATION

BY MR. COLVILLE:
Q. Morning.
A. Good morning.
Q. My name is Michael Colville. I represent the United States in this case. I just want to follow up on the testimony you just gave. With regard to the description of

the fluid, description of light green, did you see any particulate?

A. No, none. Any time there's any -- you describe it on there and I just had colored. It was fluid. That's all that came out. There was nothing but the fluid, green fluid that came out.

Q. Is that how you and all the nurses would describe meconium-stained amniotic fluid by -- that is nonparticulate as thin?

MR. PRICE: Objection, Your Honor.

THE COURT: Sustained.

Q. How do you describe meconium-stained amniotic fluid?

A. You just describe what you see, the color, the thin, thick, moderate, whatever you see. All I seen was fluid, the light green fluid.

Q. If there had been particulate that you saw on that morning or that day, would you have indicated it in the record?

A. Correct.

Q. It was not indicated in the record?

A. I did not.

Q. Have you seen the record, the entire labor record in this case?

A. I've seen -- yeah, gone over it, yes.

Q. Have you seen any part of the record where the meconium that's been described has been described as containing

particulate in it?

MR. PRICE: Objection, Your Honor.

A. No.

MR. PRICE: Is she here to interpret the medical record and other nurses' notes?

THE COURT: No. She can only speak to what she did and the notes that she wrote.

Q. You indicate the fetal strips were normal throughout your time there?

A. Perfect.

Q. Reassuring?

A. Very reassuring.

Q. You are familiar with how to read these records?

A. Very.

Q. You're trained to do this?

A. Trained.

Q. Was there anything that caused you to be concerned about a problem based upon your reading of the fetal strips?

A. There was no concerns.

Q. The vitals that you took throughout the day, anything of concern with regard to the vitals?

A. Nothing.

Q. Were there any vitals that were not normal?

A. None.

Q. Were there any signs or symptoms of an infection during

your coverage of this?
A. None.
MR. COLVILLE: Thank you.
THE COURT: Mr. Price?
CROSS-EXAMINATION
BY MR. PRICE:
Q. Good morning, Nurse Ash. We met two years ago, right, when we took your deposition, right?
A. You are the one who took it.
Q. Yeah, I'm the one. Excuse me. I don't want to go through all the records. I want to talk more about memory. Today is August 30.
Can you tell us, in the month of August, how many babies were you -- you know, did you help deliver?
A. Off the top of my head?
Q. Yes.
A. Three yesterday. Monday, two. It varies from day to day, so probably a lot.
Q. You have to perform a lot of work with labor and delivery and a lot of things go on, correct?
A. Correct.
Q. And you mentioned that some patients you might remember; some patients you might not?
A. Right.
Q. Carissa was a patient, you mentioned a sweet girl, but you

couldn't pick her out of a crowd?
A. It's been since 2014. I wouldn't promise you. There's a lot of cute girls out there, sir.
Q. Right. To a certain extent, being a nurse, you get into routines, correct?
A. Correct.
Q. And routines are good because routines keep us on track. Like every day, we have a routine of backing out of our garage. We don't have to think about that. We just do it, right?
A. Correct.
Q. And a lot of nursing, you do a lot of the same things over. You make sure the electronic medical record is complete, correct?
A. Correct.
Q. All of the notes that we saw, all of the records that you kept from 2:00 until 7:00, those were your routine, correct?
A. Correct.
Q. And as you said, you don't -- I know you just testified for a half hour about everything that happened that day, but you don't remember what happened that day, right?
A. Specifics, no.
Q. The good thing about the records is, they can tell you what you did and that could show you routine, but as to whether or not Carissa said, hey, look, I need some ice chips,

or, hey, look, you know, my boyfriend is coming in, you might not remember those specifics, correct?

A. Correct.

Q. And you wouldn't remember if there were, like, family coming in or how many people were in the room at a certain time, right?

A. Well, they are only allowed two visitors at a time. They can rotate in and out.

Q. But you might not remember if it was a mother or grandmother. You just know people are in the room?

A. Correct.

Q. You don't keep notes of who comes and goes. It's just people can come into the room, correct?

A. I don't know, because I -- I thought I saw grandparents in there. I just saw that, but other than that, I don't remember.

Q. Right. Like there are some little things that you know every day. You have to take -- like Nurse Hendershot was the nurse who took care of Carissa throughout her labor and then even after delivery, correct?

A. Correct.

Q. And if we could pull up that photograph number 1 they just took, this picture of the room, and you come into these rooms and you go out of the rooms, and you don't note every time you are in or out or who's in there or not, correct?

A. Correct.
Q. Now, Nurse Hendershot, when she is done with the delivery, she is still responsible for Carissa and Kendall, correct?
A. Correct.
Q. That's what happens. After a delivery, after you finish a delivery, you are still taking care of mom and you are also taking care of the baby, correct?
A. Correct.
Q. And you make notes with regard to the mom and you make notes with regard to the baby, right?
A. Depending on, yeah, that everything is stable.
Q. Right. I know you can chart in the mother's note with regard to how the mother is doing. Can you chart in the baby's chart as to how the baby is doing?
A. At that time, no. We chart on the fetal assessment, yes.
Q. On the fetal assessment, you can?
A. Well, on our Apgars and everything else that we perform and do, yes.
Q. For the next hour or so, if the baby is still in the room, can you make notations concerning your assessment of the baby?
A. We don't make notations. We do assess the baby when we go in though.
Q. If you had an assessment of the baby and there was something of concern, there was some note you wanted to make, just assess the baby, could you record that in the baby's

record?
A. No, but if there was any distress at all, the baby would have been taken to the nursery.
Q. And that's what Dr. Dumpe mentioned. I just want to see if this is the procedure for you as a nurse.
Whenever you have a baby, sometimes a baby might have a little bit of, I don't know, little bit of a difficult transition into life. Sometimes you have the baby and you just say to the mom, hey, look, we're just going to run the baby up to the nursery and do a full assessment just to make sure, right?
A. I don't know what you are referring to. If there was distress or something that warranted that?
Q. Just something that concerned you a little bit.
A. We can do that, yes.
Q. You have done that in the years you have been there at Heritage Valley Beaver. If there's something -- that's what the nursery is there for?
A. Correct.
Q. So the reason why I want to bring up all of these issues, like, for example, do you remember out of these babies that you helped deliver, do you remember taking them to the nursery?
A. Correct.
Q. Do you remember everyone who came with you to the nursery

this week?
A. Yes, just the fathers.
Q. And do you remember if any grandparents or anybody else came with you?
A. Never.
Q. How about a few years back? Do you remember what happened a few years back with taking babies to the nursery?
A. Since -- that hasn't changed since 1999. I mean, usually only -- there's only one person that can go to the nursery with you.
Q. Okay. I'll just ask you this: Have you ever heard of a memory called like a flash bulb memory?
A. Referring to what?
Q. In your life, there's certain events that really matter to you and you really remember events, right?
A. Uh-huh.
THE COURT: You are saying yes.
THE WITNESS: Yes, I'm sorry.
Q. For example, if you get taken to a nice restaurant, you can remember the meal, you can remember what you had, you can remember the waiters, you can remember the atmosphere. And it's a very special occasion for you, correct?
A. Correct.
Q. But you would agree with me, to the waiter, it was a Friday night, you were the couple that came in at 7:00, and he

took a look at the receipt, it said, yeah, you had the fillet and he had the salmon, right?

A. Correct.

Q. He might not remember what you were wearing or how many times you went to the ladies' room or anything like that, right?

A. Correct.

Q. And in this case, I don't want to say it's the same thing, but I'm just reading, if this is correct from your deposition, I said: I guess what I'm getting at is, like, you know, you just came from a delivery and I'm sure over the last couple of years, you have had a lot more deliveries, and I'm not saying that each one is just like the other, but is there something about your care of Carissa that sticks out in your head?

And you said: Not anything. Correct?

A. Correct.

Q. And that's what my point is, is that sometimes you might not remember events, but a family who gives birth to their first child would remember everything that happened, correct?

A. But that's what I said. We try to make it special. We do everything we can, yes.

Q. And it's special to them for their first time that they are having a child, correct?

A. Correct.

Q. And events that, you know -- I don't want to get too

personal, but do you have children?
A. One.
Q. And do you remember your birth and do you remember what happened?
A. Unfortunately.
Q. Maybe not?
A. Unfortunately.
Q. You attend a lot. We'll leave it at that. This picture of the room of the nursery -- I'm sorry, of the labor room, if you took that bed and moved it over a little bit more towards the bathroom, it looks to me, from eyeballing it, you can put two more of the hospital beds in there?
A. We can't. It's -- we transferred a patient to a maternity bed from that bed to let them stay, and it's hard to put another bed in there, no. We very rarely do that. We'll move one bed out before we would move another bed in.
Q. I know. I'm not saying you would do it, you would try to cram three beds in there, but my point is, if you move that hospital bed over to the wall, it looks to be about three feet from the wall, correct? At least three feet from the wall on the right. We are looking at the right of the picture.
A. I mean, I guess.
Q. If you push that over -- I mean, how wide is a hospital bed?
A. How wide is it? I don't know the dimensions off the top

of my head, but they are bigger beds, but I don't understand your point.

Q. My point is that yesterday, whenever the father, Matt, was asked about how big this room, he said if you pushed the bed all the way over to the wall, you could probably fit two more beds in there. Do you think you could do that?

A. I didn't know if you wanted us in there like if we had to take care of patients.

Q. No.

A. Yeah, I don't know. I mean, probably would be able to fit them, because we have rolled in a maternity bed and transferred a patient over it to transfer them out of there.

Q. And there's still room left in the room?

A. That we can walk around.

Q. Okay. Were you asked to take any pictures with the door open?

A. No.

Q. So I know you said the nurses' station is right outside there, but if the door were open, we could see that?

A. You can see that.

Q. Nurse Hackney is coming on Monday so maybe she'll take a picture, who knows, or Tuesday.

At that nurses' station, your job is to make sure that the electronic -- that's not your job. Part of your job is to make sure that the electronic medical record is complete,

correct?
A. Correct.
Q. And part of that is -- each of those blocks are clicks. You have to click in each box. You have to pull things down and answer whatever the fetal heart rate is, things like that, correct?
A. Correct.
MR. PRICE: That's all I have.
THE COURT: Ms. Koczan, any follow-up?
REDIRECT EXAMINATION
BY MS. KOCZAN:
Q. Just one question. Have you ever been involved in a situation like this where there was a fetal death?
A. No.
Q. Is this something that was unusual in the unit?
A. I never seen this happen. With how it was the day I took care of her, I would have never dreamed this would happen.
Q. And you said this is unusual. You've never seen this happen the entire time?
A. Never. If a baby is sick, the fetal heart tones don't look as beautiful as they were for me.
Q. And is that something that would make this situation stand out in your mind?
A. Yeah. I do remember. I mean, yes, it does.
Q. And would this -- again, you've never seen it. Have you

heard of it happening other than in this situation?
A. No.
Q. So this is something that would stand out in people's mind because it was an unusual situation; is that correct?
A. Yes.
MS. KOCZAN: Thank you. That's all.
THE COURT: Mr. Colville, anything else.
RECROSS-EXAMINATION
BY MR. COLVILLE:
Q. What do you mean when you say the fetal heart tones were beautiful?
A. Meaning they had the 15 by 15 accelerations for me while I was there from 2:00 to 7:00, which shows fetal well-being, when people come in for nonstress tests to test fetal heart tracings. There was no concerns with me during the whole time I traced this child.
MR. COLVILLE: Thank you.
THE COURT: Mr. Price, anything additional?
RECROSS-EXAMINATION
BY MR. PRICE:
Q. The only -- I understand that this was a very traumatic event for Heritage Valley, but as to the events that happened during your shift, you didn't understand anything about this baby's death. It wasn't until the next day, correct?
A. It would be nothing that would make me believe this would

ever happen. It was shocking the next day, yes.
Q. The next day.
MR. PRICE: Thanks.
THE COURT: Ms. Ash, I have a few follow-up questions. I try to take good notes, but I think you said you check on the mom after delivery every 15 minutes in the first hour; is that right?
THE WITNESS: Correct.
THE COURT: And then in the second hour, it's every half hour; is that right?
THE WITNESS: Correct.
THE COURT: By the third hour, you are checking once an hour?
THE WITNESS: By the third hour, they are usually over on maternity. We have to watch them for at least an hour. Don't get me wrong, if there's some problems, if they are bleeding or their vital signs, something that warranted more checks, then we check more frequently.
THE COURT: So --
THE WITNESS: But for a normal delivery.
THE COURT: By hour three, if mom has gone over to maternity, somebody else takes over; is that right?
THE WITNESS: Correct.
THE COURT: Now, how many labor rooms are there altogether at Heritage Valley back in 2014?

THE WITNESS: We have labor room 1, 2, 3, 4, 5, 6, 7, seven laboring rooms.

THE COURT: When Carissa came, were they all occupied that night or no?

THE WITNESS: I don't recall that.

THE COURT: Now, how do you keep your notes? Do you walk around with an iPad and take notes, or do you go back to the nurses' station, or do you write on a piece of paper and transfer? What do you do?

THE WITNESS: The fetal monitoring strip that comes out.

THE COURT: You write on it.

THE WITNESS: I can write on it, if -- when he came in and checked her and ruptured that forebag, I wrote on the strip.

THE COURT: All of these notes we have been looking at on the big screen, how do you enter that data?

THE WITNESS: That's on the computer.

THE COURT: Where is that computer?

THE WITNESS: At the nurses' station or at the desk, at the bedside, but usually, that one isn't always working.

THE COURT: Vis-a-vis Carissa, do you recall whether you were back out at the nurses' station or were you trying to use the one at the bedside that doesn't always work?

THE WITNESS: I was back probably at the nurses'

station. I don't remember which. If I can throw in like a universal precaution when they are getting a time-out, I'll try to do that at bedside because I'm right there, but a lot of times, that computer doesn't work.

THE COURT: Different nurses do different things. I mean, we heard testimony, for example, that Nurse Hendershot writes notes on her pant leg. You are smiling at that.

THE WITNESS: I've done that.

THE COURT: You've done that too. Sometimes too, nurses write on their hands, right?

THE WITNESS: Some do, but I wash my hands too much to do that.

THE COURT: You wash your hands too much to do that. Okay. Now, vis-a-vis Nurse Hendershot, she would have to do the same thing to enter data? She would have to go back to the nurses' station; is that right?

THE WITNESS: Correct.

THE COURT: Now, you said that you called Dr. Dumpe. Do you have his telephone number handy?

THE WITNESS: Uh-huh.

THE COURT: You are saying yes?

THE WITNESS: Yes.

THE COURT: Where is the telephone number kept?

THE WITNESS: At the nurses' station, we have all the doctors' phone numbers.

THE COURT: How about all the pediatricians?

THE WITNESS: We have them too.

THE COURT: Now, when did you come in the next morning? 7:00 again?

THE WITNESS: 7:00A.

THE COURT: And so you would have been heading up to your normal station, right?

THE WITNESS: Yeah, back in labor and delivery, yes.

THE COURT: You heard the baby was being transferred and you went up to the nursery, right?

THE WITNESS: That was, yes, around 10:00. I think we had two babies we were transferring that day.

THE COURT: And you said that when you got up there, you saw the code was going on; is that right?

THE WITNESS: Correct.

THE COURT: Do you have any recollection who was involved with the code?

THE WITNESS: Dr. Jones was there and I'm not going to name names because I'm not sure. I think Peggy Underwood. I recognized her. She is another nurse, but other than that, I could not tell you.

THE COURT: After the fact, did you ever talk to Dr. Jones about Kendall?

THE WITNESS: No.

THE COURT: Did you ever talk to Peggy Underwood

about Kendall?

THE WITNESS: No.

THE COURT: These photographs you took, that was at the direction of Ms. Koczan; is that right?

THE WITNESS: Correct.

THE COURT: When you took those photographs, you took them of the room where Carissa was?

THE WITNESS: Correct.

THE COURT: And does that room look the same today as it did back in 2014?

THE WITNESS: Yes.

THE COURT: Does the court's additional questions cause any additional questions, Ms. Koczan?

MS. KOCZAN: Yes, Your Honor.

REDIRECT EXAMINATION

BY MS. KOCZAN:

Q. In response to the court's questions, you had indicated that you keep your notes -- you write things on the strip; is that correct?

A. I try to. During an epidural, people write down what time the time-out was and what time different things go on. If -- I did make a note on my pant leg yesterday so I do do that also.

Q. Let's put up 1004 which is one of your strips, and would this be an example of the notes that you are writing on the

strip?
A. Correct.
Q. And what have you written on this particular strip?
A. That I did an AmniSure at that time and then I did a sterile vaginal exam.
Q. Let's put up 1006. Would this be another example of you documenting on the strip?
A. Yes. I called Dr. Dumpe, yes.
Q. And let's put up another one. There are several here, but we'll put up one more 1022. This again, is this more of your documentation?
A. Epidural catheter placed, yes.
Q. Down at the end, there's something else?
A. Because she is sitting up and we place her to her back. She is placed supine, yes.
Q. Is this an example of some of the notes you keep as you are going through this?
A. Correct.
Q. I wanted to go back. One other question you were asked about your documentation. When you are the nurse who is -- who has been present for the delivery, monitoring the mother, making your notes every 15 minutes for the first hour, if you would notice anything with the baby, if you observed the baby and noticed anything, would you make a note at that point?
A. You would make a note, and you would transfer to the

nursery, yes.

Q. If you as a nurse noted anything abnormal or unusual about the baby, you would do two things. You would make a note and you would take the baby to the nursery?

A. Yes, nursery notified and baby transferred to the nursery.

Q. Is that the procedure, the policy at Heritage Valley that that's what you are to do?

A. Correct.

Q. Other than that, observing something unusual, are you required to make any documentation about the baby during that first two hour period?

A. No.

MS. KOCZAN: Thank you. That's all.

THE COURT: Mr. Colville, anything further?

MR. COLVILLE: No, Your Honor.

THE COURT: Mr. Price?

MR. PRICE: No.

THE COURT: Ms. Ash, just a couple questions. Now that you recognize Ms. Peronis here, do you have any recollection of any discussions that you might have had with her during her labor?

THE WITNESS: I don't, no.

THE COURT: And can you describe for me generally what happens at change of shift?

THE WITNESS: We give a report to the oncoming nurse.

THE COURT: And about what time does that start?

THE WITNESS: At 7:00P or 7:00A, whatever time the shift is ending.

THE COURT: So what does a report entail?

THE WITNESS: You give the age, the gravida, the para, the gestation. Gravida and para is how many pregnancies, how many deliveries, how much weeks gestation from her EDC, her estimated due date is her gestational age, so how far along she is, then the progress of she came in. You just tell them your report of the day. She came in, ruptured membranes and AmniSure was positive. She has an epidural. She was positive and we kept her. She is three centimeters. You tell them dilatation and anything you can report on, what IV bag is up, what fluids are running.

THE COURT: And you know, without recalling this specific day, but in general, how long does it take you to give a report?

THE WITNESS: Moments. I mean, it's minutes. You usually have all the information in front of you.

THE COURT: And once you give the report, the person receiving it can ask questions, right?

THE WITNESS: Correct.

THE COURT: Now, on this particular day, there were not one but two babies who were having problems, right?

THE WITNESS: That was the next morning, Monday.

THE COURT: That was the next morning. So to that end -- let's strike that.

So by the way, when do you generally get in?

THE WITNESS: 6:45, 6:40.

THE COURT: Does report start right then, or does the report start at 7:00?

THE WITNESS: 7:00.

THE COURT: So report is what? About five minutes or so?

THE WITNESS: Correct.

THE COURT: Thank you. Ms. Koczan.

MS. KOCZAN: I do have follow-up on that.

REDIRECT EXAMINATION

BY MS. KOCZAN:

Q. The report you were talking with the judge about, is that the report in the labor area?

A. Correct.

Q. Not in the nursery?

A. Correct.

Q. In the nursery, would there be more patients, more babies?

A. Correct.

Q. Would you have to give report on each one of those babies?

A. I don't work at the nursery.

Q. You wouldn't know what they do?

A. No.

MS. KOCZAN: Thank you.

THE COURT: Anything further? Mr. Colville now has a question.

RECROSS-EXAMINATION

BY MR. COLVILLE:

Q. When you are working in the labor and delivery, are you assigned to more than one patient?

A. If they are laboring patients, no. It's one to one.

Q. So on this day, when you were with Carissa, you were solely dedicated to her?

A. One to one, yes.

Q. When Nurse Hendershot came in to replace you, she would have been one to one with Carissa as well?

A. Yes, one to one.

THE COURT: Ms. Ash, you may step down. I don't think Ms. Ash is subject to recall. Ms. Ash, you may step down. Thank you for your appearance here today.

(Witness excused.)

THE COURT: Ms. Koczan, you had indicated that in addition to displaying the photos that you did, that you were going to pass the photos to the jurors. Do you want to do that at this point?

MS. KOCZAN: Certainly.

THE COURT: Mr. Galovich will assist. He has his own set. Let the record reflect that Mr. Galovich will be passing

the photographs that Nurse Ash took altogether. So as you did with the baby photographs, you should review it and then pass it on.

Let the record reflect that each of our jurors has had an opportunity to review the entire stack of photographs that depict the labor room. At this time, it's just about 10:25.

Ladies and gentlemen of the jury, without you, we got started here this morning for some legal matters. I'm sure Ms. Leo needs a break. I need a break, so we're going to take our break now and get back together at quarter to 11:00.

Once again, let me give you the recess instruction. Once again, you are not to discuss this case yet. You are not to talk to family members and friends about it, communicate about it with anybody here that you might see, anybody that might want to reach out to you by telephone or otherwise today.

Once again, I don't know if there's any news coverage about this case. To the extent there is, you would have to ignore it, and you can't do any research either directly or indirectly or by way of the Internet. Continue to keep your open minds. Enjoy your break. We'll get started again at 10:45.

(Jury excused.)

(Recess taken.)

MR. COLVILLE: Your Honor --

THE COURT: I heard. We're going to hear from Dr. Jones.

(Jury present.)

THE COURT: Thank you, Mr. Galovich. Ladies and gentlemen, I trust you had a good break. The court did. I understand Ms. Koczan is ready to call her next witness, Dr. Jones.

MS. KOCZAN: That's correct, Your Honor.

THE CLERK: Please state and spell your name for the record.

THE WITNESS: Hilary Jones H-I-L-A-R-Y, J-O-N-E-S.

(Witness sworn.)

THE COURT: Dr. Jones, you've heard me repeatedly say watch the step. Despite maintenance's efforts, it's not entirely even. Once you are situated, please arrange the microphone so you are speaking into it. Thank you.

Ms. Koczan, you may proceed.

MS. KOCZAN: Thank you, Your Honor.

HILARY JONES, M.D., a witness herein, having been first duly sworn, was examined and testified as follows:

DIRECT EXAMINATION

BY MS. KOCZAN:

Q. Doctor, can you please state your full name for the jury?

A. Hilary Sara Miller Jones.

Q. And, Dr. Jones, what is your occupation?
A. I'm a pediatrician.
Q. Are you licensed to practice medicine here in Pennsylvania?
A. Yes.
Q. Are you licensed in any other states?
A. Yes, Ohio.
Q. And where do you currently live?
A. In Beaver, Pennsylvania.
Q. And how long have you lived there?
A. Since -- I've lived in Beaver County since 1994. In my current house since 1998.
Q. Are you married?
A. Yes.
Q. Do you have any children?
A. Yes. I have two daughters.
Q. And how old are they?
A. 15 and 18.
Q. And what do they do? Are they in school?
A. My oldest one just started college this week. My younger one is a sophomore in high school.
Q. Would you tell the jury about your education, starting with your undergrad bringing us up through medical school?
A. I attended West Virginia Wesleyan undergraduate. I majored in biology with a minor in chemistry. I graduated in

1990 with a BS in biology. Then I attended West Virginia University Medical School and graduated in 1994 with my M.D.

Q. After completing medical school, did you go on for additional training?

A. Yes.

Q. Can you tell the jury about that?

A. I did a three year pediatric residency at Todd Children's Hospital in Youngstown, Ohio.

Q. Let me stop you there and ask you to explain to the jury. They've already heard some of this, but the field of pediatrics, what is it? What sort of patients do you see, conditions do you treat, et cetera?

A. We see patients from birth up until 18 to 21 years old usually. It depends when we cut off the age. We treat well babies, we treat sick children, we treat chronic illnesses, preventive care, immunizations. I treat -- I do inpatient and outpatients. I treat them while they are in the hospital. I treat newborns in the nursery. I don't know what else.

Q. And since you completed that, you said that was what? Internship and residency in pediatrics?

A. They don't do internships anymore. You just do residency.

Q. You completed that in what year?

A. 1997.

Q. After you completed that residency in 1997, what did you do next?

A. I joined the practice that I'm currently in in Beaver, Pennsylvania.
Q. And what is the name of that practice?
A. It's -- the name now is Heritage Valley Pediatrics.
Q. What was the name when you joined?
A. I don't know. They changed several times. They had just been acquired by the hospital when I joined the practice. It was Tristate Pediatrics and I think they had something like Children's Hospital Alliance of Beaver at one point.
Q. So the name has changed?
A. Yes.
Q. But now Heritage Valley Pediatrics?
A. Heritage Valley Pediatrics.
Q. I want to talk about the time period in 2014. In addition to yourself in 2014, who were the other members of the group?
A. In 2014, we've always had a lot of pediatricians. I mean, you want me to name everybody?
Q. Yes.
A. I'll go in order from the ones who have been longest. Dr. Haddad, Dr. Liljestrand was still there, Dr. Scibilia, Dr. Cahill, and then I was next in line, Dr. Deacon, Dr. Wisler, I think Dr. Amerigo Ceccarelli was part of our group then, Dr. Barbara Negrini, Dr. Alpa Arora, Dr. Sarah Bahr and then we had several physician assistants and possibly nurse practitioner then. I'm not sure.

Q. Does this practice have more than one office?
A. Yes.
Q. Can you tell the jury where the offices are located?
A. We have an office in Sewickley. We have an office in Hopewell. The main office in Beaver. We have an office in Chippewa and we have an office in Calcutta, Ohio.
Q. What offices do you go to?
A. I'm generally in Calcutta, Ohio, Beaver and Chippewa. Occasionally I'll go to Hopewell.
Q. You've told us already that in addition to seeing pediatric patients in the office, you also see them in the hospital?
A. Yes.
Q. And how does that work? Are there certain days you are in the office, certain days you are in the hospital?
A. We rotate through. Generally when we are in the hospital, it's our call weekend. So we'll start at 8:00 a.m. Saturday, work in the office. We see the patients in the hospital, work in the office Saturday, Sunday. We take all the calls, Sunday morning. We see patients in the hospital and take all the calls into Monday, and then starting Monday, we go to the hospital in the morning and then start office hours at 1:00 p.m.
Q. We've heard in this case that your involvement is rounding in the nursery. Do all of your partners round in the nursery

or just certain?
A. Not all of them. Just certain ones do. It depends on -- I think I know Dr. Haddad doesn't go to the hospital anymore. At the time, I think pretty much everybody did a week in the hospital. The PAs don't.
Q. When you talk about doing a week in the hospital, are we talking about the nursery?
A. Yes. Well, we see patients that are in the nursery, and if we have any pediatric patients that have been admitted to the floor, we see them as well.
Q. And can you tell the jury what your responsibilities are with regard to the nursery?
A. In the nursery, I come in every morning and see the well newborns. We always have newborns in there. The census is always that we have at least somebody there. We see the well newborns and examine them, write our notes, talk to the moms. If we are discharging somebody, we give them instructions on discharging, and then if there's any other babies that are in there that need other care, we take care of them, and then after I'm done with the nursery, if there's any inpatients, I'll round on the patients on the floor.
Q. Those inpatients would be pediatric patients?
A. Yes, only pediatrics.
Q. Do you have a typical hour every day that you come to the hospital to see patients in the nursery?

A. Yes, because I have to teach the residents as well. I'm limited to the time that I can teach the residents and round, and I like to get there right around 8:00 so that I can start rounding and we can see the patients together and then see the pediatric patients, and then if there's time left over, I can lecture to them or teach them something or if they have questions, I can answer them.

Q. Was that your practice back in 2014? To get to the nursery at 8:00 a.m.?

A. Yes.

Q. And was that typically what you did every day without deviation?

A. Yes.

Q. Are there also occasions in which you would get call to attend a delivery?

A. Yes.

Q. Under what circumstances might you get call to attend a delivery?

A. It would vary. If the obstetrician wanted the pediatrician there for whatever reason, they just call us and say we need you for a delivery and we go in and attend the delivery.

Q. Do you get called every time there's meconium present?

A. No.

Q. And do you get called every time there's a vacuum

extraction?
A. No.
Q. Do you get called when there's a prophylactic McRoberts Maneuver performed on a patient?
A. No.
Q. Does Heritage Valley have policies and procedures -- I believe Dr. Dumpe has talked about that and the nurses -- that dictate when they call; is that correct?
A. Yes.
Q. Moving back to what we were talking about before, do you have any other responsibilities either in the hospital or in the practice that we haven't discussed yet?
A. I don't think so.
Q. Are you board certified?
A. Yes.
Q. And in what areas are you board certified?
A. Pediatrics.
Q. And what did you have to do to get board certified?
A. When I first took the test back in 1997, we had to travel and sit for a test that lasted eight hours one day and eight hours the next day, and then every seven years, I believe, we have to recertify, where we have to go to a testing center and sit down and take a computerized test.
Q. And have you passed that certification test each time you take it?

A. Yes.
Q. Are your hospital privileges at Heritage Valley Beaver?
A. Yes, and Sewickley.
Q. That was my next question. Is there any other place that you go to?
A. No.
Q. Have you, in the past or presently, held various positions at Heritage Valley Beaver?
A. Yes.
Q. What sort of positions have you held?
A. The chairman of the department of pediatrics. It's just a rotating position. They have to have a pediatrician who will take the position of chairman of the department. We just attend meetings and sign documents.
Q. And during the course of your practice, have you been the recipient of various honors or awards?
A. During my practice, I've had several honors and awards when I was in medical school.
Q. Can you tell the jury about a couple of those?
A. In medical school, you get -- we don't get grades. We get pass/fail/marginal pass/honors. If you get over 97 percent in class, you are awarded an honors. I believe I got honors in psychiatry, clinical medicine, pediatrics, and then my fourth year, I was awarded the -- they gave an award for the most outstanding pediatric medical student, and I received that my

fourth year.
Q. What made you decide to go into pediatrics?
A. A couple of things. Number one, I enjoyed it. I was good at it. I like taking care of the kids. It's challenging in that you have to figure out what's going on with a patient that a lot of times can't tell you what's wrong, but kids are -- they are innocent and when they are sick, they are sick, and it's just rewarding to take care of them.
Q. Before we start talking about your care in this particular case, I wanted to speak about some of the medical conditions that the jury has been hearing about. First and foremost, we've heard a lot about meconium, but from your perspective what is meconium?
A. Meconium is the baby's first bowel movement. In utero, the baby is swallowing amniotic fluid, and the lining of the intestine sheds, bile is produced, and all of this stuff gathers in the intestines and into the colon, and that essentially forms a substance that they excrete as their first bowel movement.
Q. That is the meconium; is that correct?
A. Yes.
Q. And what causes meconium to be present in amniotic fluid?
A. If the baby has a bowel movement, it will be present in the amniotic fluid.
Q. And under what circumstances might that happen?

A. It can happen -- anything that could potentially cause some stress to the baby, they might have a little bit of meconium that passes or sometimes larger amounts.
Q. And meconium, is that -- is it full of bacteria?
A. No.
Q. Like adult stool would be?
A. No. It's sterile. The whole environment the baby is in, the amniotic sac is very protected. It protects the baby, and there's no bacteria for the baby to ingest. There's no bacteria in the baby's gut, which is another reason that babies -- immune defenses are not developed, and so there's no bacteria in the gut yet.
Q. Okay. And the fact that a baby may pass meconium into the amniotic fluid and that show up at the time of delivery, given the fact that it's sterile, is every baby that passes meconium, are they at risk for infection?
A. Not necessarily, no.
Q. And why is that?
A. Well, the meconium is sterile, like I said. It's not going to introduce bacteria into their lungs, not the meconium itself. Meconium, if it gets into the lungs, can cause different issues, but not because of a bacterial infection it introduces.
Q. I'm going to ask you some more questions about this in a minute. Let me ask you this: From the pediatric perspective,

are you aware of the various categories of meconium?
A. Yes.
Q. Thin, what does thin meconium mean?
A. Essentially that it's staining the fluid, the fluid is still clear. There's just a little bit of coloration to it.
Q. The term moderate that we've heard, moderate meconium, what does that mean?
A. It's a little bit more colored.
Q. Heavy meconium, what --
A. Well, heavy or thick?
Q. Thick.
A. Thick meconium is -- it's thick. It's like -- we always described it as pea soup, and I've been to deliveries where the baby comes out and it's like they are swimming in pea soup, and it's very apparent.
Q. And we've heard this term particulate and nonparticulate. What does that mean?
A. Well, the particulate is just that you can see the consistency. It's very thick. Like I said, it's like a consistency of pea soup, and that's the best way I can describe it because that's what it looks like.
Q. And thin or moderate meconium, are these things concerning?
A. I mean, not as much as if you had a baby that was in the thick meconium. I mean, there's always some concern. You

don't want them to ingest a whole bunch of it. Not ingest. They swallow all of this stuff, but inhale.

Q. And is the presence of meconium during the labor, is that something that's unusual?

A. It happens fairly frequently. I believe -- I don't know the numbers myself. I believe one in five is what we had said, but I mean, it happens relatively frequently.

Q. So one in five deliveries, there's meconium there?

A. I believe that was the number that we had heard.

Q. So when there's meconium present, what sort of problems can that cause for a newborn? We're just talking about meconium.

A. Just the meconium?

Q. Right.

A. If they inhale it and it gets into the lungs, it can cause some issues with the gas exchange in their lungs. In meconium -- do you want me to talk about actually aspiration of meconium?

Q. Yes.

A. Aspiration of meconium, it causes problems in three different ways. The first way is that if it gets in there, it can cause what's called a chemical pneumonitis.

Q. What does that mean?

A. Pneumonitis is irritation of the airways. It's like if you inhaled something that was noxious and your airways get

irritated, and that's one of the things that it can cause.

The second thing, if it's thick and particulate, it can cause what's called like -- the best way to describe it is a ball valve mechanism, where the airway is blocked with this thick, sticky substance. When the baby inhales, air goes in. The airway is dilated, and then when they try to exhale, they can't get the air out, and the problem that that creates is not so much with the air exchange. They get the air in. They can't get the air out, but air keeps going in. It's like blowing up a balloon, and eventually, they develop what's called a pneumothorax, where the lung essentially pops, and that can cause all kinds of issues.

Q. Anything else?

A. It can result in what's called pulmonary hypertension. There are a lot of physiologic changes that go on whenever a baby is first born. They don't need their lungs in utero, so the blood vessels are clamped down very tightly, and the pressure in the blood vessels is high because they don't need a lot of blood going to their lungs because they are not exchanging gas in the lungs in utero while they are in the mother.

When they are born, there's a whole bunch of changes that happen, chemical changes that causes blood vessels to dilate. Lots of blood goes to the lungs. They start breathing. Gas exchanges, and they transition into the environment outside

where they need their lungs because they no longer have the placenta.

And sometimes, any kind of inflammation and irritation causes blood vessels to clamp down, and it's called pulmonary hypertension where those blood vessels get tight again and the gas exchange doesn't occur as well.

Q. I'm going to stop you there and ask you about treatment. The first thing that you talked about is it can cause an irritation, and I think you used the word pneumonitis?

A. Pneumonitis.

Q. Do you have to do anything about that?

A. It depends. If it causes symptoms, then we treat the symptoms. We don't treat meconium aspiration unless there's actual symptoms.

Q. The mere fact that a child has meconium in their amniotic fluid, are you telling us that you don't just treat that?

A. No. Only if they develop symptoms from it.

Q. The fact that meconium is present, does that put them at higher risk of developing an infection?

A. It can cause -- they can develop pneumonia later on simply because if there's a lot of meconium in there, sometimes within a couple of days, it can act as essentially a substrate for bacteria to start taking hold and give them a pneumonia.

Q. You said later on?

A. Yeah. Usually it's within a few days.

Q. Few days after delivery?
A. Yes.
Q. And one of the other terms that I believe we've heard about, I think some of the experts that have taken the stand have talked about, the term is ascending infection.
What does that mean?
A. An ascending infection is one that actually ascends into the uterus. Like I said, the amniotic sac is a protective membrane that's there to protect the baby from this environment that's outside in the outside world.
Ascending infections, generally the urinary tract in women has a lot of bacteria in it and that bacteria can move upwards into the -- through the cervix into the uterus, and if there's a disruption in the amniotic sac for any reason, then it can get in and potentially infect the baby. Viruses can as well.
Q. And in this particular case, we know, the jurors already heard that this baby had an E. coli sepsis?
A. Yes.
Q. Was that the mechanism of how that infection got there? Ascending infection?
A. Yes. I mean, yes.
Q. We've heard the term transitioning. I think you started to explain that. What does that term mean?
A. Transitioning, it's just a complex process. Like I was saying, when babies are in utero, they are in this nice, warm,

liquid environment. They don't need their lungs. The placenta provides all of the nutrients and oxygen, carries away the waste and carbon dioxide that the body produces, and there are a whole bunch of different -- fetal circulation is very different from the circulation that newborns and adults have. There are blood vessels that are needed in utero that aren't needed. There are holes through the chambers of the heart that are needed in utero and are not needed outside.

And again, the blood supply to the lungs is very minimal in utero because really the only reason for blood to go to the lungs is to actually supply the lung tissue to feed the lung tissue. They don't need to exchange gases in the lungs in utero.

We were explaining transition, so transition actually can start before they are born. The labor induces a bunch of chemicals to be released that cause a whole bunch of changes. The fetal lung tissue, there's fluid in the lungs that's supposed to be there. It's secreted by the alveoli in the lungs. Some of it is amniotic fluid. Not all of it. A lot of it is secreted by the lung itself.

And prior to birth, there's surges of different chemicals called catecholamines that cause changes in the air sacs to start the resorption of the fetal lung fluid to prepare the baby for breathing once they deliver, and these blood vessels close and pressures change, once they are born and they take

the first breath, the pressures change in the lungs, the blood vessels dilate, vessels close.

The pressure between the chambers of the heart changes and blood starts flowing in other directions because it needs to go in other directions. Instead of bypassing the lungs, it needs to go to the lungs now.

Q. So that is the transition process?

A. Yes.

Q. How long can it take for a newborn to actually go through the process?

A. Well, there's pulmonary transition and circulatory transition. The pulmonary transition can take hours to a day or two. The circulatory transition can take up to six weeks.

Q. And are there various -- I'm going to use the word -- issues, signs, symptoms, issues a newborn might have as part of that transition process?

A. Generally, in newborns, we talk a lot about pulse oximetry. The amount of oxygen in the fetal blood is actually pretty low. You or I have our pulse ox in the high 90s usually. Babies in utero, their pulse ox is usually in the 50s, and during labor, it can drop as low as the 30s. It just depends.

Once they are born, we expect them to have specific levels of oxygenation at certain periods of time, and we usually go between -- at a minute, we want them to be 60 to 65 percent

saturated. At two minutes, 70 to 75 -- or 65 to 70 and 75 -- from one, two, three, four, five, and at ten minutes, the oxygen saturation, we want it over 85 percent.

Q. And when babies are transitioning, can they have respiratory issues?

A. Yes, they can.

Q. And what sort of respiratory issues would a baby have during transition?

A. Sometimes just breathing a little bit faster or needing a little bit of supplemental oxygen. Some babies are slow to transition, and they can require a little bit of supplemental oxygen for up to a couple of hours after birth.

Q. And in addition to transitioning, are there other problems that can cause respiratory issues in newborns?

A. Yes.

Q. What would they be?

A. Respirations in newborns, there's something called respiratory distress syndrome, and that particularly deals with the lungs being immature. They weren't quite ready.

There's a substance called surfactant that's produced in the last few weeks of pregnancy, and the surfactant coats the insides of the alveoli and allows them to stay expanded once they expand. They have been clamped down for months, and this substance essentially holds them open once the baby starts breathing.

If they are immature, the lungs aren't ready, they weren't quite ready to be born, sometimes they'll develop what's called respiratory distress syndrome. It's primarily a lack of surfactant, and that can cause them to breathe a little bit fast, to have the flaring, the grunting, a little bit of an oxygen requirement, and this sometimes resolves quickly on its own, and sometimes they need a lot of support.

Q. I want to stop you and ask you about those terms you just used. Flaring. What is that? What does that mean?

A. Nasal flaring is a movement. When you breathe, normally you just -- air goes in and out of your nose, and it doesn't move. If you are working to breathe, you can see that it's a movement that the nostrils will kind of flare outwards and relax back inwards when they are breathing.

Q. We were shown a still photograph there yesterday, and I believe one of the witnesses, I think it was Kylee, pointed and said, yes, that's flaring.

Can you see flaring on a still photo?

A. It's a movement. You can't see it in a still picture.

Q. It's something you have to observe in terms of movement?

A. It's a movement.

Q. The next thing you mentioned, grunting?

A. Yes.

Q. What is that?

A. Grunting creates what we call peep or positive and

expiratory pressure. Like I said, the alveoli, they have been expanded, and when the baby takes its first breath, they expand and you want to keep them expanded because it's easier to breathe. The air goes in and out.

If there's surfactant there, coating that area, they stay expanded fairly well. If there's no surfactant there or their lung compliance or the lungs are stiffer, then if they are more difficult to keep expanding, the baby will inhale, and every time they exhale, the alveoli clamp down, and they have to inhale a lot harder to get them to expand. What they'll do is they'll create this peep by grunting. Can I demonstrate it?

Q. Yes.

A. When you see a baby grunting, they are like (demonstrating) because they are actually holding their lungs open. When they are grunting like that, it helps expand the alveoli and keep it open.

THE COURT: Just let the record reflect that the doctor imitated for the jurors what grunting is. Go ahead.

Q. And this grunting, is this something that you as a pediatrician can hear?

A. Yes.

Q. A nurse would be able to hear?

A. Yes.

Q. That's something pretty obvious?

A. Yes.
Q. And we heard another term here, and I don't know if you used it before, but retraction. What does that mean?
A. Retraction, there are different types of retractions. Normally when you breathe, your diaphragm does the work. Your diaphragm is a muscle that you don't have to think about moving, and it just moves up and down and helps expand your lungs and then it relaxes and the air goes out.

Accessory muscles are muscles that you can use in addition to your diaphragm to breathe. When you are having trouble breathing or there's -- you need to work harder to breathe, you'll use these accessory muscles. The ones in between your ribs are called intercostal muscles, and you'll have intercostal retractions.

I usually describe to parents when I say what to look for, if it looks like the baby is -- every time they breathe, you see their ribs and their ribs seem to be sucking in every time they breathe, those are called intercostal retractions.

You have substernal retractions under here (indicating).
Q. You are pointing to your sternum?
A. Yes, bottom of your rib cage. They will breathe and use those abdominal muscles and that will sink in.

And suprasternal retractions which are not as frequent in babies, but you'll see suprasternal retractions when they are really, really working. This area right here (indicating),

the suprasternal notch at the top of your sternum will actually suck in when you are breathing.

THE COURT: Again, the witness is pointing to the sternum and also demonstrating. Go ahead.

Q. And, Doctor, we had -- we were talking about respiratory issues and that's how we got on that discussion. Can infection cause respiratory issues?

A. Yes.

Q. And can infection also cause pneumonia?

A. Yes.

Q. And I think we showed in the opening, but I'd like to put them back up and have you explain this. 1364. This is in the joint binders also. I think 1365 also. Will this help you illustrate what pneumonia is?

A. Yeah. Yes.

Q. Can you explain what pneumonia is, and I have another drawing too. I think that was maybe 1363. This one might be easier. 1362 maybe. Here's one with the baby. Is this better? Which one would you like?

A. This is fine. I mean, pneumonia -- there's different types of pneumonia. When you think -- usually when you think of children or adults that have pneumonia, it's because they've had a cold or something that's caused a disruption in their defenses of their airways, and we all have bacteria everywhere. There's bacteria in your airways. There's

bacteria in your bronchial tubes, and our body takes care of it, but sometimes the defenses are broken down, and one or two of those bacteria will take hold and start dividing and cause pneumonia in a section of the lung.

Specifically with neonatal pneumonia, that's usually a more diffuse process. For some reason, the bacteria get, through this vertical transmission, will get into the airways and they are everywhere and it takes hold and infects a lot more of the tissue. It's not so much a consolidation as much as a diffuse process.

Q. And you've seen the autopsy report and whatnot. Is that what was described there?

A. Yes.

Q. Let's go to -- if we go to the next in the series there. I think that was maybe 1363. Does this help at all to explain how it works or what happens?

A. Yes. I mean, the bacteria in the alveoli cause inflammation, irritation. The body's immune system wants to fight it off. It goes to that area and starts trying to kill the bacteria.

In the process, it causes a lot of damage to the tissues in the area as well. It releases chemicals. It releases fluids, makes cells leaky so fluid builds up, and when that happens, the gas exchange is compromised, because the alveoli -- there's not as much air in there and the cell walls

can't exchange the gas the way they are supposed to.

Q. Now, we have heard about some of the laboratory work that was done here. We'll talk about that a little bit later, but I just want to talk about the concept. We've heard about white blood cells and we've heard about a differential which include things like neutrophils, lymphocytes, that type of thing.

Can you briefly explain to the jury what that all is about and what that tells us and what happens in infection?

A. We get the CBC to give us a clue as to whether or not there is infection, to look at other things as well that can be causing the respiratory distress. The white blood cell count, the number of red cells in there, the hemoglobin level that's in there, are they anemic, are they polycythemic, too many red cells, and we look at the platelets as well, because they can be an indication of inflammation as well in laboratory response.

The white blood cells are what we primarily look at to decide whether or not there's infection, and they could be either very, very high or very low in a newborn that would make you think there's infection.

The differential is, they take a sample of the blood, a smear of the blood on a slide and they put a stain on it, and they look at it under a microscope, and they take a field and they count how many of each cell is in that field, so we can

get a percentage of how many neutrophils are there, lymphocytes, monocytes, eosinophils, basophils, immature cells. Give us a clue as to what's going on.

Q. We heard here in this case that when the laboratory work that you ordered came back that she only had -- Kendall only had three neutrophils?

A. She had three percent neutrophils.

Q. What does that mean? First of all, tell me what is a neutrophil?

A. Neutrophils are the main infection fighting cells in the blood. Those are the ones that really work to destroy bacteria and infection, and you want the ANC or the absolute neutrophil count, which is we take the number, we look at the number of white blood cells reported on the CBC and we take the percentage of neutrophils that are there and figure out what the ANC is using those numbers, and ideally you want it over 500. Anybody should be over 500.

If you drop below 500, your ability to fight infection is severely compromised.

Q. And in this particular case, with the three percent neutrophils, what would that ANC come out to be?

A. I would have to see the numbers.

Q. Is it around 2 something?

A. I don't remember what her white count was.

Q. We'll look at it. One of the other things that we saw in

that differential and with Kendall's case, there were 95 percent lymphocytes. First of all, tell us what a lymphocyte is?

A. Lymphocytes are another white blood cell that help fight infection, but primarily lymphocytes, we usually see more of dural viral infections. They are better at fighting viral infections.

Q. You mentioned something else. Eosinophils, is it?

A. Eosinophils.

Q. What are they?

A. Eosinophils are just another group of cells. Usually they are responsible for causing your allergies and hay fever.

Q. Any other pertinent cells in the differential?

A. The cell that I was looking at was the neutrophils and any immature cells. The presence of immature cells indicates that the body is really trying to produce more white cells to fight infection.

Q. And we've talked about pneumonia generally. Let's talk now about E. coli. First and foremost, what is E. coli?

A. E. coli is a gram negative rod. It's a bacterium that is present in -- mostly in the GI tract. It can be in the genital urinary tract. Everybody has it in their GI tract.

Q. And what is -- we'll start with E. coli pneumonia. What is E. coli pneumonia?

A. It's pneumonia that's caused by E. coli bacterium.

Q. In terms of the characteristics of this pneumonia, is this a virulent or aggressive, or is it not virulent?
A. It's very virulent and very aggressive.
Q. And what is the significance of that?
A. The significance of E. coli -- neonatal sepsis, neonatal pneumonia are usually caused by -- the majority of them are caused by an organism called group B strep. Group B strep is in the genitourinary tract of a lot of people. Most of the cases, neonatal sepsis are due to group B strep.

The next organism that we see percentagewise is E. coli, but it's like the majority of them are group B strep, and a smaller number are E. coli and other organisms. The E. coli is a gram negative rod.

Gram negative infections are fairly serious. Do you want me to go into that?
Q. Yes, if you could.
A. Treating a gram negative rod -- any kind of gram negative bacteria -- gram positive and gram negative is a distinction we identify the bacteria by looking at it with a specific stain called a gram stain. It takes up the stain or doesn't take up the stain. It just indicates the type of cell wall that the bacterium has.

When you have a gram negative infection and you start treating it, the cell wall breaks down and releases something called endotoxin, and the endotoxin causes an inflammatory

response in the body that can overwhelm the body.

It causes chemicals like tumor necrosis factor to be released, and essentially what your body is trying to do to protect you is actually hurting you as well. There's regulatory systems that keep it from -- when you have infection, there are systems in the body that say, okay, this is enough. It's helping, but we can't get too much of this, and we need to let the body heal a little bit.

In a gram negative infection, these systems go haywire, and the inflammatory response creates a cascade of chemical release and inflammation that can create all kinds of problems and destroy organs and be extremely serious. It can lead to a condition called DIC, which stands for disseminated intravascular coagulation. That is very difficult to treat. Requires a lot of supportive care and frequently results in death.

Q. And the E. coli infections in the neonatal population, what is the percentage of mortality in that area?

A. From what I have read in the articles and journals, E. coli sepsis, in and of itself, just looking at E. coli sepsis and spectrum of newborns, that generally 41.7 percent of babies that develop an E. coli neonatal sepsis will die.

Q. We've also heard -- we saw these safety rules that Mr. Price has put up there, and one of them was the sooner you treat with antibiotics, the better.

Do you generally agree with that?

A. You want to treat as soon as you notice the symptoms, yes. As soon as you are suspecting that there's infection, you want to start treating.

Q. Okay. Is it with all of these infections that the sooner you get the antibiotics on, the better it's going to be, or are there some infections where it doesn't make any difference?

A. It depends on how advanced the infection is. The antibiotics take time to work. They are not going to work right away. You want to get the antibiotics in, and as I said, part of the problem with treating gram negative infections is that when we treat and the antibiotic comes in and causes fissures in the cell wall, it releases this endotoxin and creates this cascade of problems that you may end up having to deal with.

Q. So in E. coli sepsis, are there circumstances where it doesn't make any difference when you give the antibiotics if the infection is advanced enough?

MR. PRICE: Objection, Your Honor. She is leading.

THE COURT: Agreed. Your witness. Open up the question.

MS. KOCZAN: I will rephrase.

Q. Doctor, are there circumstances with E. coli infection that that isn't the situation, that the earlier you treat, the

better?
A. There's circumstances with any infection that once you notice the symptoms and start treating, if it's past the point where it's going to help, it's not going to make a difference.
Q. One other topic and we're going to move on to your care of Kendall, and we've heard a lot about Apgars. I know different people have explained those. I would like you, from the pediatric perspective, to talk about that and I'm going to use Kendall's as an example here.
If we can put up 1115 which is the delivery note and highlight that top section. Would you, first and foremost, explain what is an Apgar? What does that stand for?
A. Apgars are a score that we give the babies that kind of give us a snapshot of their well-being at a minute of life, at five minutes of life, and then if we need to, at ten minutes of life.
Q. What is it that you are assessing as part of the Apgar scores?
A. These five things that you see. The heart rate, we want the heart rate to be -- in order to get a two, the heart rate has to be over 100. We don't want the heart rate below 80. If it's below -- if it's between 80 and 100, they get a one. If it's below 80, they get a zero.
Q. You said you want it over 100?
A. Yes.

Q. For a neonate, brand new baby like this, what is the range that you want the heart rate to be in?
A. Anything over 100, and generally, I've seen babies have heart rates of 160 to 170, but generally a baby's heart rate is between 140 and 160.
Q. So is the range then 100 to 160, 170?
A. Anything over 100 is good, but when you get up into the 180s, you are talking about tachycardia or too fast of a heartbeat.
Q. So you told us that in order to get a two, it has to be above 100?
A. Has to be over 100.
Q. The second category, respirations?
A. Respirations.
Q. Tell us about that.
A. Baby is born and they are not breathing, they get a zero. If they are not making any effort to breathe, they get a zero. If they are breathing, they get a one. If they are crying, they get a two.
Q. That's the difference then?
A. Yes.
Q. Next is muscle tone.
A. Yeah. The tone we want babies usually have -- you want their extremities flexed and them to have good tone. If they are just laying there flat, their arms are extended and legs

are extended, that's a zero. If they are brought in a little bit, then they get a one, and if they are up like this (indicating) and their knees are bent and their hips are flexed, they get a two.

Q. The next category is reflex. What is that?

A. That's essentially just how they respond to stimuli. If you are drying them off and agitating them, do they respond to that stimuli? If they don't respond at all, they get a zero. If they are moving around a little bit, they get a one, and if they are really not liking what you are doing, they get a two.

Q. The next one is skin color.

A. Skin color, if they are blue, they get a zero. If they are pink but have blue hands and feet and blue around their mouth which is called acrocyanosis, they get a one, and if they are completely pink, they get a two.

Q. Is it unusual for a newborn to have that acrocyanosis?

A. No. It's very common.

Q. Is that something that could persist?

A. Days or weeks.

Q. Days or weeks? Is that what you said?

A. Days or weeks.

Q. Let's look at the total scores then. This baby here at one minute got a six. What does that tell us?

A. Essentially it means she was vigorous but not -- it's not perfect but it's okay, and generally we want it to be over

seven and so -- she wasn't crying yet, which I mean, her tone -- I wasn't there. From the pictures that I've seen, I may have given her tone a two.

Q. In the pictures that we've seen here in the courtroom --

MR. PRICE: Objection, Your Honor. Now, they are treating my photographs when they weren't there. I don't believe -- I think it's improper for them to speculate.

THE COURT: I think that the doctor has rendered an opinion based on the photograph that she saw that she might have given it a two. I don't see any problem with that, Mr. Price. Go ahead. All these photographs are in evidence.

Q. You were talking about the photographs the jury has seen and that are in these books, correct?

A. Uh-huh. Yes.

Q. And at the five minute mark, the baby was up to an eight. First of all, tell us, is an eight a good thing?

A. Yes.

Q. Is that a normal, healthy baby?

A. Yes.

Q. What does that tell us that she's got a score of eight?

A. That she is vigorous, she is breathing, her heart rate is good and it's -- like I said, it's a snapshot of how well they are doing at that moment in time. And five minutes, having an Apgar of eight, that's a perfectly normal Apgar.

Q. While we are on this, let's take a look at this

assessment. I'm going to ask you some questions about that too. At the bottom kind of the left-hand side, Nurse Hendershot has testified about this, but this is the baby's assessment that is done in the nursery. If you could just walk us through and tell us what are we looking at at these various things and what does it mean.

Under general appearance, what is it you are looking at?

A. Just what does the baby look like. Does it have any genetic defects, is there anything, just glancing at the baby, that looks abnormal.

Q. This one was marked as norm, correct?

A. Yes.

Q. The next thing under there is skin?

A. If they have any lesions, any birth marks, any open wounds, bruising, things like that.

Q. Head and neck?

A. We look at the fontanelle which are the openings in the front of the skull.

Q. Is that what we refer to as the soft spot?

A. The soft spot, yes. Whether there's molding. When babies are born vaginally, their heads -- the bones of their skull are in several different pieces, and the reason for that is so their head can change shape when they come out of the birth canal. Some babies have pretty pointy heads when they come out.

Q. I've heard them referred to as cone heads.
A. Yes. We assess whether there's any edema. Being born, it's rough, and it can cause swelling on their scalp as well, so we'll mark that down as well.
Q. Eyes?
A. Whether the eyes are present, whether they are in the correct place.
Q. The ENT?
A. We look at the ears to make sure they are in the right place on the head, they are not low set, high set, that they are there, that they are open. We look at the nose, whether the nostrils are patent or open, and check their pallet to make sure they don't have a cleft pallet.
Q. The thorax?
A. The symmetry of the chest, make sure --
Q. It's equal?
A. Equal, yes.
Q. Lungs?
A. How their lungs sound.
Q. And what are you doing that with? A stethoscope?
A. Listen with a stethoscope, yes.
Q. Heart?
A. Just that the heart is beating regularly, there aren't any murmurs or abnormal sounds.
Q. Abdomen?

A. That the abdomen is well developed, that there isn't any opening, that the umbilical cord -- the umbilical stump is developed normally, and we feel for their liver and kidneys and spleen, any masses it might have in their belly.

Q. Under genitalia?

A. Whether they are male or female. On the boys, we make sure the testicles are descended, that there's not any ambiguous genitalia where you can't tell if it's a boy or girl.

Q. Trunk and spine?

A. Just essentially the spinal column looks developed and it's not open in any places or have any dimples at the bottom.

Q. Extremities, what are you looking at?

A. If they have ten fingers and toes and everything looks like it's proportionate. With extremities as well, I include the hips. We make sure the hips aren't dislocated.

Reflexes, just how they respond to noxious stimuli. We are irritating them, essentially picking them up and undressing them is irritating to them.

Q. And the last one is the anus.

A. That it's patent, because some babies are born without the anal opening being patent.

Q. I know this is the nursery assessment. Is this the first assessment you would do when you first see a baby?

A. Yes.

Q. And this was all marked as normal?
A. Yes.
Q. What does that tell us looking at those Apgars and looking at this? What does that tell us about the condition of this baby?
A. That after birth, she looked good.
Q. We've heard some testimony from Dr. Shore and Dr. Karotkin yesterday that, with this assessment, had a pediatrician been called, there would have been nothing to do. Would you agree with that?
A. I agree. I wouldn't have done anything.
Q. And would you have made -- this assessment, would that require a baby to go to the nursery?
A. No.
Q. Would you have made any recommendations at that point?
A. No, nothing out of the ordinary, no.
Q. And the ordinary is what?
A. We have standard orders of what to look for. The nurses will -- if the baby has anything abnormal on their exam on any kind of assessment, if there's a problem, then they will take the baby to the nursery. The nursery nurses decide whether or not they think something needs to be done.
Q. If you had been called to attend the delivery with this assessment, would you have started any antibiotics? Including the fact that there was meconium, would there be any need to

start antibiotics?
A. No.
Q. I'd like to move on now at this point and start talking about your treatment of Kendall, and on October 13 of 2014, were you covering the newborn nursery that day?
A. Yes.
Q. At any time prior to you arriving at the hospital that day, did you receive a call regarding Kendall Peronis?
A. No, I did not.
Q. And we have seen a document that was authored by Janet Kincade. First and foremost, do you know who she is?
A. I don't really remember her. She was a nursing supervisor at the time.
Q. There's an indication in her note that you were called at 7:20 and I want to start with this. Did Janet Kincade call you at 7:20?
A. No, she did not.
Q. Did anybody call you at 7:20?
A. No, nobody called me.
Q. Are you sure of that?
A. I am positive.
Q. That morning, did you receive a telephone call from Jamie McCrory?
A. I did not.
Q. Did you receive a telephone call from Bradley Heiple?

A. I did not.
Q. We saw these yesterday, but I'd like to put up your pager records, and before I do that, I wanted to ask you this question: If the nursing staff, and that would include supervisors, nurses or even Dr. Heiple, needs to get ahold of you back in October of 2014, what are the mechanisms to do so?
A. They can either call my cell phone directly or they can use our Cortext paging system, which they call our paging company, they type in something that sends a text. We use the Cortext because of HIPAA. It's secure and it will send a notification to my phone, the app on my phone, that tells me that there's a call, and they get notifications as to whether or not I read that, and if we haven't read it within five minutes, they will send it again.
Q. And you said it's either the pager system that you just described; is that correct?
A. Yes.
Q. Or your cell phone?
A. Yes.
Q. Do they have a home phone number for you?
A. I don't even have a home phone.
Q. So the only way they could get in touch with you?
A. My cell phone.
Q. And the pager?
A. And my Cortext pager.

Q. Let's take a look at those. We saw those yesterday, but I'd like to put them up again. 1355 is the first one. I want to go through these with you.

If we can just highlight the first one over there. The judge noted yesterday the redactions. That would include patient name. That was taken out for HIPAA purposes, correct?

A. Yes.

Q. And whoever called. So let's take a look at that first one. Let's see the time on that. The time on that would be at 8:01 a.m. on the 13th which would be the day of Kendall's birth?

A. Yes.

Q. This is --

A. Dr. Shumway from the ER.

Q. Calling you?

A. Yes.

Q. Does this have anything to do with Kendall?

A. No.

Q. The time is 8:01, so that wouldn't be a call that was referenced by Janet Kincade; is that correct?

A. No.

Q. Let's look at the next one. Can you tell the jury what time that one is from?

A. That one was at 12:48 a.m.

Q. Obviously that's not about this baby?

A. No. That was a parent calling with a question.
Q. The baby or son had a fever for the past couple of days, calling now, due to has not been draining. That's clearly not Kendall.
A. No.
Q. Let's go to the next one. We can look at the time there. That's what?
A. That was at 12:38 a.m.
Q. Let's go to the top of the next page, top of that page. Again, in terms of the time, that would be before Kendall was even born, correct?
A. Yes.
Q. The description?
A. That was a patient, a parent calling with a question.
Q. Let's go to the next one. This one occurred the day before, so this couldn't be a call about Kendall?
A. As you can see at the bottom, it says when the text was sent and when it was read. Those are the read receipts I was talking about, so if we didn't check it, it pops up on the computer we didn't see it or check it.
Q. Let's go to the next one that starts on the bottom of that page and goes to the next page. What time is this one?
A. That one was October 12, which was the day before.
Q. Kendall wasn't even born yet?
A. No.

Q. That's from a Dr. Cahill?
A. Yes. He's in our office.
Q. Let's go to the next page of records then. Let's take a look at that. This is from the day after?
A. Correct.
Q. So this wouldn't have been about Kendall?
A. No.
Q. Let's go down to the next one, and this is October 13, but this would have been at 9:21 p.m.?
A. Yes.
Q. It's about a child having stomach pains, so this isn't Kendall?
A. No.
Q. Let's go to the next one. This is at October 30 at 9:11 p.m. Let's look at the content of that, and again, first of all, the time isn't right and this is about a child with headaches and an ear problem.
A. Yes, that's another parent calling.
Q. Let's go to the next one. This is October 13, again, 8:10 p.m. That would be long after and it's about a baby or child that was in a car accident. That would not be Kendall?
A. Yes, 15-year-old.
Q. Just so the jury is clear, you requested copies of your paging records, correct?
A. Yes.

Q. This is what you were given?
A. Yes.
Q. These are the complete paging records for those days?
A. Yes.
Q. Now, let's look at the cell phone records, and again, can you tell us how those -- go to the first page, which is 1358. This is the letter from Verizon verifying, is that correct, that they have given you a complete copy of the cell phone records for that day?
A. Yes.
Q. Let's take a look at the cell phone records, and if we could just highlight those portions that talk about the 13th, because that's all we really need to look at.
On the 13th, it looks like the first phone call, at least that is recorded, is 12:40 a.m., 12:52 a.m., 11:52 a.m. Kendall wasn't even born yet, correct?
A. Correct.
Q. So they couldn't be about her?
A. Can you make that bigger so I can see?
Q. Do you want more of the side of it? Is that what you are looking for?
A. Yeah. I have old eyes.
Q. So we have one we looked at 12:40 a.m., 12:52, 11:52. The next one after that isn't until 1:03 p.m. So there is nothing on here about a call after 5:20 which is the time she was

born?
A. Correct.
Q. Up through 1:03 p.m., correct?
A. Correct.
Q. And other than these two records, is there any other way that you could have been called that day?
A. No.
Q. Let's put those down.
MS. KOCZAN: Your Honor, we're going to move on from there. Might this be a good time to take a break?
THE COURT: This might be a good time to take our lunch break. Ladies and gentlemen of the jury, we're going to take our lunch recess. Once again, leave your notepads as well as your exhibit binders there on the chair. Mr. Galovich will collect them.
As you've just heard not too long ago, you are not to talk about the case yet amongst yourselves, not communicate with anyone else about the case, not do any research, not look for any news accounts. Again, continue to keep an open mind as we go through these proceedings. There are other witnesses we have to hear from and possibly other exhibits, and as you know, you haven't had the final instructions in the case nor the attorneys' closing arguments. With that, let's take our lunch break and be back at 1:15.
(Jury excused.)

THE COURT: Doctor, you may step down. You've already taken the oath as indicated. You shouldn't really be talking about your testimony over this lunch break. You can talk about the Steelers loss, your daughter, sending one off to college. You can check in with your husband. You can check in with your office. You can do all those kind of good things but not talk about the substance of your testimony not only with your attorney but the attorneys for the government and/or Dr. Dumpe. We'll see you all back here to start again at 1:15.

(Luncheon recess taken 11:58 a.m. -1:14 p.m.).

(Jury present.)

THE COURT: Ladies and gentlemen, I trust you enjoyed your lunch break. Ms. Koczan is ready to go. Dr. Jones has already resumed the stand.

MS. KOCZAN: Your Honor, may I begin?

THE COURT: Yes.

BY MS. KOCZAN:

Q. Dr. Jones, before we took our lunch break, we were talking about the pager records and whatnot. And again, I don't mean to be repetitive, I want to make sure I asked you. Pager records, cell phone, that would have been the only way to get you?

A. Yes.

Q. There would be no other way for somebody to contact you?

A. No.
Q. So when was the first time you heard anything about Kendall Peronis?
A. When I walked into the nursery.
Q. What time was that?
A. 8:00.
Q. And when you -- again, is that your normal time of arriving every day?
A. Yes.
Q. Can you tell us what happened? You walked into the nursery. What do you see? What do you find?
A. I walked in and there were two warmer beds with babies on them. The resident was there and Nurse McCrory, and they were directing me toward Kendall, and I said, well, we have this baby over here that's on O2 and working a little bit to breathe, and we have this other baby over here, and at the time I don't recall if any of the other newborns were in there, but after that, it was just those two babies.
Q. Okay. We're not going to talk about the other baby, any detailed terms of the baby's condition, but was that baby stable at that moment?
A. Yes.
Q. You've heard Jamie McCrory testify. You were in the courtroom when she testified about what she said. Is that your recollection?

A. Yes.
Q. And why was that your reaction?
A. Why was that my reaction? That she talked about?
Q. Yes.
A. Because I hadn't been called. I walked in thinking that I was just going to see some babies and we were going to do rounds and talk to the moms and go and sit down and talk, and I walked in to a whole lot of other stuff going on.
Q. Were you mad at the resident for not calling you?
A. I was frustrated, because he knows that he can call me any time and I just said why -- I remember saying why didn't you call me. He said I knew you were going to be here.
Q. And to you, was that a reasonable explanation?
A. At the time, yeah. I mean, it really didn't make that much difference at that point, because I was driving in anyway.
Q. Even if he had called you when he got there, and the jury has heard there's some discrepancies about what time, but let's assume he was there at 7:45 and he called you, how long would it have taken you to get in there?
A. I was on my way at that point. I was already driving.
Q. And how far do you live from the hospital?
A. It's about 15 to 20 minutes door to door.
Q. And had he called you -- you were present also when he testified about his findings. Had he called you and told you

that, what would you have done?
A. If he had called and told me what he found, I would have said, all right, I'm almost there.
Q. So if you could pick up. You've walked in, you see this baby. Tell me about the -- tell the jury about the conversation with Dr. Heiple. What did he tell you at that time?
A. He just essentially said we have this baby over here. She is on some oxygen. She had a little bit of meconium at delivery. She is breathing a little bit fast, and I want you to take a look at her, and he presented the other baby to me as well.
Q. As he's presenting these babies to you, are you evaluating the baby?
A. Yes.
Q. Was there any conversation with Nurse McCrory at that time, or was it primarily with Dr. Heiple?
A. She essentially told me the same thing. She was standing there, and she said, you know, this baby is here, and I do remember she held up the suction catheter and said, here, I got this junk out of her, and she is on, I think it was 60 some percent O2, but her stats were about 94 percent at the time. She just presented the basic history and told me what was going on with her.
Q. I want to stop you and ask you about -- I think you

said -- I think I heard this, I got this junk out. Is that what she said?
A. Yes.
Q. What did it look like?
A. It was tinged mucus. It was green-tinged mucus.
Q. And any other information either from Dr. Heiple or from Nurse McCrory at that time?
A. No. They just gave me a basic rundown what was going on with the babies.
Q. And this is at 8:00 a.m.; is that correct?
A. Yes. At that point, shortly thereafter.
Q. So after you get the rundown on Kendall and this other baby, what do you do next?
A. I said -- I looked at Kendall. I listened to her and I walked over and looked at the other baby, assessed the other baby, and I said neither one of these can stay. And --
Q. Why was that?
A. Well, the one baby was clearly a surgical problem and that was going to need to be addressed, and Kendall, I didn't -- I don't keep babies that are on more than 40 percent oxygen and she was on 60. I think 64 is the number that sticks out in my head, 64 percent oxygen to keep her saturations into the 90s, and I like -- I don't keep them if they are that high simply because I would rather transfer a stable baby that may get better than keep a baby and end up trying to transfer an

unstable baby if she gets worse.
Q. Now, you said stable. At that point, was Kendall stable?
A. She was having a little bit of trouble breathing and she was on a relatively high amount of oxygen, but she didn't look that bad when I got in there.
Q. The way you are testifying, and I just want to make this clear, you have a recollection?
A. Yes.
Q. Do you have a clear recollection?
A. Yes.
Q. So tell us about the rest of your evaluation of Kendall. You told us you listened to her heart, her lungs. What else?
A. I listened to her heart, lungs. I looked at how much oxygen she was on, how much she was working to breathe, and we checked for their perfusion, look at their skin, how well they are perfusing, that's important. We press on their skin and see how quickly -- when you press on somebody's skin, it gets pale, and we let go to see how long it takes for it to refill.
Q. And we've heard about grunting, flaring and retracting. When you got there at 8:00, was Kendall doing any of that?
A. She was retracting a little bit, and from my recollection, I felt she was breathing -- she was working to breathe, but she was not grunting at that point.
Q. And was she flaring at all at that point?
A. I don't recall that she was flaring.

Q. You said she was just working to breathe?
A. Yeah, she seemed like she was working to breathe.
Q. And after you did your evaluation, you said -- you've told us that you immediately made up your mind that neither that other baby or Kendall could stay?
A. Yes.
Q. So what happened next?
A. I told the resident, I said I want everything done, which they know the CBC, the blood culture, I get cap gases, so that I can get an idea of how effectively the baby is breathing.
Q. What are cap gases?
A. There are three types. You can get arterial, you can get venous, or you can do capillary. It's easy on the newborns to get the capillary. You just have to do the heel stick and draw it up in a little pipette tube, and you can't really assess the oxygen level, but I have the pulse ox for that, but you can look at their pH, which gives me an idea of how the acid based balance in the baby and the carbon dioxide and bicarb levels.

The CO2 is what I'm really looking at to see how effectively the baby is breathing, because if the baby is breathing effectively, the CO2 will be around 40. In some newborns, it's up to 50 and I'm okay with it being around 50 in a fairly large term newborn, because they have the musculature to actually breathe effectively. They don't get

tired as easily as smaller, premature babies do.

Q. So about what time was it that you told the resident I want everything?

A. It had to have been shortly after 8:00. I mean, it was as soon as I assessed her. I said go ahead and get everything and the chest x-ray as well.

Q. At that time, did you also order an IV?

A. Yes.

Q. And did you also order antibiotics at that time?

A. Yes.

Q. And was your order a verbal order?

A. Yes.

Q. So you verbally told them to do that?

A. Yes.

Q. And is that unusual?

A. In a crisis situation where we are -- I say crisis. In a situation like that where you want things done right now, I would give the verbal order. I say do this, do this, do this, and then at some point, we have to put it in the computer so the lab has the labels and all the things that need to be sent, but at that point, I just want them to get the stuff going, get the IV and get the blood drawn.

Some of the stuff can be done through a heel stick and some of it need -- the blood culture has to come from an actual vein. They have to draw the blood culture a specific

way, and it has to be done in a sterile manner so that we don't get skin bacteria on there that mess up the labs, that give you a contaminant, and you need to get the blood culture in order to start the antibiotics and get the IV in.

Sometimes it's very difficult to get IVs in these babies. They got hers relatively quickly.

Q. The jury has seen some documentation that the IV went in at about 8:20 a.m. Does that sound about right?

A. Yes.

Q. We've seen documentation about blood work. We'll look at that in a little bit. Just so I understand and the jury understands the timing, 8:00 you come in. You do your assessment. You give orders, and orders are within what time frame? 8:00 to what?

A. That I gave the orders?

Q. Yes.

A. Or they were carried out?

Q. Let's talk about you did your assessment. How long does it take you to do the assessment and give the orders?

A. Five, ten minutes. Not long.

Q. So we're talking about anywhere from 8:05 to 8:10 is when you would have given the orders?

A. Yes.

Q. And so you give the orders. What happens next?

A. They start carrying out the orders, and I went over

into -- we have a little dictation room where our telephones are and I called West Penn Hospital. We have a good relationship with West Penn. The neonatologists there know me and we can call directly and say, hey, I have this baby. This is what's going on. I need you to come get them.

And I presented both babies to them knowing that the other one was most likely going to have to go to Children's because we use West Penn and Magee for premature babies, respiratory problems, feeding problems, blood sugar problems, but Children's Hospital, if they have a cardiac issue or surgical problem, they'll go to Children's.

Q. And do you recall who you spoke with?

A. Dr. Leneri, L-e-n-e-r-i.

Q. We've heard the name Giovannia Leneri. Is that the doctor?

A. Yes.

Q. Was Dr. Leneri willing to accept Kendall in transport?

A. Yes. They are very good at that. They say, fine, we'll come get them.

Q. So can you give the jury some estimate what time that was that you called?

A. It was probably between 8:15 and 8:20.

Q. I think we've seen some documentation from Nurse McCrory when she testified that it was around 8:20 that you were making arrangements for transfer.

A. Yes.
Q. Does that sound accurate?
A. Yes.
Q. So you make the arrangements for transfer, and you are still in the nursery at that time; is that accurate?
A. Yes.
Q. You can see Kendall?
A. Yes.
Q. So what happens after you make the arrangements for transfer?
A. I had the residents -- whenever we transfer, we have to get consent. So I don't think anybody had talked to the parents at that point, so I told the residents to get my consent forms, and we walked down to the room, down the hall to the maternity area, and I spoke with Carissa and Matt first, and I just essentially told them your baby is having a little bit of trouble breathing. She is on more oxygen than I would like to see her on. It's something that would be better handled downtown, so I'm going to send your baby downtown.
Q. And we saw it yesterday, but let's put this up, 1177. Is this the consent form that you had the parents sign?
A. Yes.
Q. If you can scroll to the bottom there. And that's Carissa, and then it looks like you signed it after that?
A. Yes, and a lot of times -- I can't say whether this was

the case or not, but a lot of times, I'll have mom sign and take them back down to the nursery and sign, because I had two consents I had to do and just sign them both at the same time.

Q. And when you went to see the parents, did anyone go with you?

A. I believe Dr. Heiple went with me. I don't know if any of the nurses went with me. Usually, if I'm going to talk to a mom whose baby is in distress, I'll talk to the nurses' station in maternity and I'll say who's taking care of whoever and have them come with me, simply because they already have a relationship with mom and are taking care of her.

Q. And when you had this conversation with mom and -- mom and dad both, correct?

A. Yes. I believe -- there were usually a lot of people in the room, more than just Carissa and Matt. I think there were more people in the room than just Carissa and Matt at that point.

Q. Is it the situation that you believe Dr. Heiple was there also?

A. Yes.

Q. And did Dr. Heiple say anything or did he leave all the talking to you?

A. No. They just follow me.

Q. We've heard testimony yesterday from Matt that the very first encounter with you, that you seemed to be out of your

element, I think was the terminology, and if I've misstated, the jury's recollection is what counts, out of your element or broke down at that time. Was that the situation?

A. Not that I recall. I mean, I was trying to express that this was a problem that we needed to take care of. I have had parents that would have refused transfer, and I've had to convince them that their baby needs to be transferred, but no.

Q. And you didn't have to convince these parents?

A. No.

Q. They were willing to --

A. Yes, they did right away.

Q. -- sign the consent?

A. Yes.

Q. So in terms of the antibiotics, you ordered the antibiotics. Tell us what did you order?

A. Ampicillin and gentamicin.

Q. Let's start with the ampicillin. Why did you order the ampicillin?

A. Neonatal sepsis is treated with -- the standard is just give them ampicillin and gentamicin. Ampicillin covers gram positive organisms such as the group B strep. Gentamicin covers the gram negative organisms such as E. coli and a couple other ones that we think about when we're treating for sepsis.

We give them two antibiotics because we don't know

what we are treating and we have to cover a broad spectrum of bacteria that we possibly could be covering.

Q. I neglected to ask you, once you had evaluated Kendall that morning, what was your impression? What did you think was going on at that point?

A. At that point, I -- we start thinking -- you always have what we call a differential diagnosis in your head. You just run through. She is clearly in respiratory distress. Is it because she has infections? Is it because of the meconium? Is it because she just has respiratory distress? Could it be transitional? Could it just be TTN? TTN stands for transient tachypnea of the newborn. It's a condition that some newborns have where they just breathe fast. Sometimes they need a little bit of oxygen, and sometimes they don't need oxygen, but they are just breathing fast for a day to I've seen it last for five days.

But those are things you think about with a newborn, but we always treat as if it's an infection, because that's the first thing that we need to do because that needs to be treated, so you always work them up as if it's infection.

Another thing too, we have a chest x-ray to get an idea of what their lungs look like and make sure they don't have a pneumothorax or something like that.

Q. Was there -- was infection -- you have talked about the term differential diagnosis.

A. Yes.
Q. We hear doctors talk about what was high on their list of differential and what was down. Was the infection number one on your differential diagnosis?
A. Infection is going to be -- I tend to think of the things that are worse, the worst things down to the more treatable, less serious things, so like I said, infection is always going to be at the top of the list, which is why we treat all of these babies as if they are infected.
Q. And you told us the two antibiotics that you chose, and we've seen some records here that indicate that Kendall got her first ampicillin at around 8:34, 8:35. Let me ask you about that.
MR. PRICE: Objection.
THE COURT: I'm sorry?
MR. PRICE: Objection.
THE COURT: Basis?
MR. PRICE: That's an incorrect fact.
THE COURT: Fact not stated in the record. Perhaps you need to rephrase the question.
Q. Dr. Jones, do you know what time Kendall got her first antibiotic?
A. I would have to look at the record.
Q. We'll pull that up in a minute. When you order the antibiotics, are they right there on the floor, or do they

have to come up from the pharmacy?
A. No. They have to come up from the pharmacy. They have to be calculated based on the baby's weight, and we put the order in or call the pharmacy. Usually, when we have something like this, we'll put the order in and call the pharmacy and say, hey, we need this stuff.
Q. And then does the pharmacy send it up?
A. Yes. They send it by the bullet tubes.
Q. The tube system?
A. Yes.
Q. And Kendall had one IV?
A. I believe she had one.
Q. Can you run the ampicillin and gentamicin at the same time?
A. No.
Q. So explain to the jury how that works.
A. You have to run antibiotics over a certain length of time because they are what we call hypertonic. There's a lot of -- the solute level is very high in them and it can be damaging to the blood vessels if you run it too fast or push it through. It has to be mixed a certain way into a certain volume and it has to be infused over a specific amount of time.
Usually they hook a pump up that infuses that volume over a certain amount of time and pushes it into the vein just so

that the vein doesn't get sclerosed and you'll either blow the IV or lose the vein altogether, and then you don't have your IV anymore.

Q. Ampicillin, what is the time frame you run that over?

A. The ampicillin has to go in over 30 minutes.

Q. Okay. So it would be 30 minutes from whatever time they timed it, 30 minutes to infuse that into the --

A. Yes.

Q. After that, are you able to give the gentamicin?

A. Yes.

Q. Now, you talked about ordering some laboratory work. Let's just take a look at that. That's 1140 and 41. And if you can just explain to us what this is and what information is provided to you?

A. The bedside glucose, a lot of times these babies have blood sugar issues. That's another thing we have to watch carefully, because their respiratory symptoms could be because their blood sugar is low, so we always check blood sugars on them. Hers was 115, which is -- it's marked as high, but we want it over 40/60 so that's fine. I'm okay with it being 115.

Q. Okay. So what is the next thing?

A. This is the differential which I didn't get back. That takes a while because they have to stain the slide and look at it under the microscope. That's the one that shows the three

percent segmented neutrophils and 95 percent lymphocytes. She only had one monocyte.

This atypical lymphocyte that you see and the nucleated red blood cells are the immature cells that we tend to see in higher amounts when the bone marrow is working overtime to try to push out more blood cells to fight infection.

Q. So what does this lab work tell us? What did that tell you that day about Kendall?

A. That day, I didn't care about this, because at that point, this wasn't back yet and I was treating my patient. I ordered the labs, and some of the quicker ones will give me a clue as to what's going on, but I'm going to treat my patient based on what I see right then and there.

Q. So one of the other things -- let's go to the second page of that, too. If you can just explain what's on there and what that tells us.

A. That's just more of the -- that's just a different way. This is the computer generated -- the machine generated differential. The machine generates a differential and gives it to the lab, but the other one you saw was actually them staining the slide and looking at it under the microscope. Somebody actually looks and it and counts cells with a little clicker.

Q. We saw at the bottom the white blood cell was count was 8.3. What does that tell us?

A. She had 8. -- 8,300 white blood cells per unit.
Q. Does that give you any information?
A. It's a little bit low for a newborn, yes.
Q. And one of the other things you did -- let's put up 1127. I think this was the initial chest x-ray. Is this the first one?
A. Yes.
Q. Can you explain to the jury what this chest x-ray, what the findings were and what they meant?
A. It was read -- you want me to read the findings? The heart looks fine. That's another thing. The respiratory issues could be cardiac as well. That's why we listen to their chest. I didn't hear any murmurs or anything.

When we get the chest x-ray, that also gives us an idea if the heart is big, if the heart is misshapen, it will give us a clue as to whether there's an underlying cardiac issue.

The heart did not appear enlarged. Pulmonary vascularity is difficult to evaluate given the background. Pulmonary parenchymal opacities, meaning that the lungs were so whited out it was difficult to see the blood vessels that were there.

Q. What would cause the lungs to be so whited out that it was difficult to see --
A. The pneumonia.
Q. Go on.

A. There's a right basilar consolidation, which meant, as I was saying consolidation is when there's a specific area of the lung that is infected and sometimes the consolidation can look the same -- something called atelectasis can look the same as consolidation on an x-ray.

X-rays are a snapshot in time. They are like reading shadows. You say it could be this or could be this and put together your assessment based on the clinical picture of what's going on with the patient.

So when the alveoli kind of don't inflate really well, they can cause atelectasis which can look like consolidation or it could just be atelectasis.

Then there's a probable small right-sided pleural effusion. Pleural effusion is just fluid that's outside the lung but inside the membrane that surrounds the lung, and that's more of an inflammatory response to the irritation that's in there from the infection.

And then again right-sided apical consolidation, same as what was in the right base, and air bronchograms. The air bronchograms just kind of -- the lung tissue is so apparent as opposed to the dark area where the air is going through the bronchi that you can see them very clearly on the x-ray.

Air bronchograms at the medial right base suggest right medial basilar consolidation. Again, there are ropey bilateral perihilar and peribronchial densities.

Q. What does that mean?
A. It means that that area of the lungs are whited out more.
Q. And then the radiologist says there's no evidence of pneumothorax?
A. Correct.
Q. What does that mean and what is significant about that?
A. The pneumothorax, like I said, we look for, especially in cases of meconium aspiration, that that ball valve effect has essentially popped the lung, and you see air outside of the lung and the lung can't inflate against that air.

It creates a -- there's a potential space, meaning it's a space that's there but isn't there when everything is functioning properly, and when the alveoli essentially pop and develop a leak, the air goes into that section of the lung and the lung itself deflates, and it's very difficult to inflate against that pressure of the air that's in there, and every time they take a breath, it gets bigger and bigger, but that wasn't there.

THE COURT: Once, again, the witness is demonstrating. Go ahead.

Q. What is the significance -- the jury has heard about meconium. What is the significance of the fact that there was no pneumothorax?
A. The significance of that is that the lungs were well -- that there was no pneumothorax. It's important because that's

something that needs to be treated.
Q. So let's go down to the impression. If you would explain that to the jury.
A. Overall consolation of the findings -- I think that's supposed to be constellation of the findings, but that says consolation of findings most equivalent with meconium aspiration and/or neonatal pneumonia in the proper clinical setting.
Q. At this point in time, when you got the results of this chest x-ray back, what were you thinking was going on at that point?
A. That this was either pneumonia or that there was meconium, and he noted the small right pleural effusion.
Q. And we've heard testimony here that after you went out and talked to the parents, got the parents' consent to transfer, you came back to the nursery, correct?
A. Yes. I walked across the hall to tell the other parents that I was sending their baby as well, and I actually felt badly because they had more questions and I cut them off. I said, look, just sign this, please. I will be back to talk to you and left and went back to the nursery.
Q. And you did that why?
A. Because I wanted to get back to the nursery.
Q. For Kendall?
A. Yes.

Q. So you come back to the nursery. What happens at that point?

A. I walk back in, and the nursery, it's all glass. Even when you walk in through the doors, there's glass in the hallway and there's glass on the left as you walk in. I looked over, and I think at the time too, Jamie had said to me she is on a little bit more oxygen, and I walked back in and took a look at her.

At this point, she was working really hard to breathe and she was on a lot more oxygen, and saturations had dropped, and I think she had put her up to almost 100 percent O2 and I didn't like the color of her skin. She was what we call mottling, which means that she is not perfusing her skin very well.

I remember saying to her are any of the labs back yet and they weren't, and I then asked how far West Penn was away, where the helicopter was or did they give us an ETA, and I think they were trying to figure that out, and at that point, I said you know what, never mind. Just give me the intubation tray. I'm going to tube her.

Q. And we know that the West Penn team, based upon the records, arrived at 9:45. And there's documentation in the records that we'll look at in a minute that you intubated her somewhere around 9:40?

A. It was right before the West Penn team got there.

Sometimes we'll end up calling West Penn back saying, hey, this baby looks like this now. What do you want me to do? They'll say don't intubate or don't do this, but I didn't even bother. I wasn't going to not tube her.

Q. And the term intubate or tube, what does that mean?

A. That I put an endotracheal tube into her trachea so we could better oxygenate her. What we do beforehand, we have what's called an Ambu bag, it's a bag with a mask that we can put over the baby's nose and mouth, and we can actually force air into the lungs so the baby is not actually having to use her muscles and her body to move air in and out.

And when you get to the point where you are having to bag the baby, you have to put a tube down. You can bag a baby for a long time if you have trouble getting a tube down, but the best thing to do is get the tube down so you can adequately oxygenate the baby.

Q. Up through this period of time, have you personally suctioned this baby at all?

A. Have I?

Q. Suctioned her.

A. Suctioned her?

Q. Yes.

A. I don't think I suctioned her until I was doing the intubation.

Q. So let's talk about that. Did the suctioning occur prior

to the intubation or after the intubation?
A. That I suctioned her? It was during, because they have a lot of secretions and bubbles, and it makes it very difficult to see, because I take the laryngoscope, which is a metal handle with a blade on the end. It's shaped like the letter L and has a light on it, and we put it into the baby's mouth and use it to pull the tongue forward and get the trachea in a position where we can actually see it so we can put the tube in, because if we were to stick the tube into the baby, it will go into the esophagus every time because the trachea is too far forward, so we have to move the anatomy so we can see it and put the tube through the vocal cords into the trachea.
Q. Tell the jury what you saw when you looked down there.
A. She had a lot of secretions that were just bubbly and mucusy.
Q. Did you see any meconium at that time?
A. No, not -- no, I didn't see any meconium then. I remember because I had to suction all of those bubbles and mucus out of the way so I could see the trachea and vocal cords.
Q. Are you then able to intubate her to get that tube in on the first attempt?
A. Yes.
Q. And after you gets the tube in, do you have to suction more?
A. No. I put the tube in and then we put a sensor on it that

has a little purple film, so when we bag, it defects carbon dioxide. So when we push the air in, when the baby actually exhales and we let go, it goes through that sensor and turns yellow, and when it turns yellow, you know that you have a tube in the right place, so that, you know, that you are not bagging her esophagus accidently, because it's difficult to do sometimes, but we do that to confirm tube placement, that the tube is actually in the trachea.

Q. Were you able to confirm tube placement?

A. Yes.

Q. Once you got the tube in, was somebody Ambuing her?

A. Probably me.

Q. You were actually standing there forcing air in?

A. Yes.

Q. So tube is in. What happens next?

A. I order chest x-ray. The tube was in and I actually ordered -- I don't know if I have them do the bolus beforehand or not. I think I ordered the bolus before. I had them run the fluid bolus before I intubated her, because at that point, we were bagging her anyway and her circulation -- I was concerned about her circulation, so I had them bolus her with fluids to increase her blood volume and improve her perfusion.

Q. Let's put up document No. 1114 which is the second page, the delivery record, the second page. It would have been 1116.

This is -- the jury has seen this before. Jamie talked about this the other day. It gives some times on here, chest x-ray. Jamie has testified that the times on there reflect the time the vitals were taken, not necessarily what is gone over there.

She is documented there you intubated the infant, various things happen. Is that consistent with what you recall? Not necessarily the times but the actions.

A. Yes.

Q. And you also made a note, correct?

A. Yes.

Q. I think that was the 1114, and it would be 1113 and 1114, if we can put that up too. Before we go to that, let me just ask you. You made some handwritten notes too, and I want to pull those up and ask you some questions about that. Let me get those out.

What we have on the board right now is your final summary. And if you can -- we can highlight the first page and I just want to ask you some questions about that, in terms of the documentation about what we discussed thus far.

A. Do you want me to read it?

Q. If you can generally summarize for the jury. What is it you are documenting? Let's take the top part, because I think that's where we are at right now.

A. The history of what was going on. The baby girl Peronis,

what time she was delivered, mom's information. She was 19, first baby, first delivery, vacuum vaginal delivery, birth weight was eight pounds, seven ounces, 3840 grams. Meconium was present in the amniotic fluid at delivery. Baby was stained with meconium. Apgars were six at one minute, eight at five minutes. Baby was brought to the nursery in mild respiratory distress and was placed on oxygen under the hood to maintain her saturations over 90s.

Upon my arrival in the nursery at 8:00, a.m., the baby was on 64 percent oxy hood, maintaining sats 94 to 96 percent but was still grunting, flaring, retracting head -- I don't know why that says retracting head. That's probably a typo. I wouldn't have dictated that. And coarse lung sounds.

Heart was regular without murmur. Perfusion was good. At that point, because of the high oxygen requirement, it was decided that the baby should be shifted -- that should be shipped to West Penn for further care.

I spoke with Dr. Giovannia Leneri at West Penn and arranged for transport at that time. Chest x-ray was obtained. IV access was obtained. Blood cultures, CBC and capillary blood gasses were obtained and sent.

Ampicillin and gentamicin were started. I spoke with both parents regarding the baby's condition and need for transfer and they were in agreement.

Upon my return to the nursery at 9:00 a.m., the baby's

condition had deteriorated. The pulse ox -- that should say was in; that's more likely was in -- the upper 80s and oxygen requirement had gone up and the baby's work of breathing had increased.

The capillary blood gas had not returned yet. The results are not returned from the lab, but at that point, I decided that I was going to go ahead and intubate the baby.

The West Penn team was already en route and was approximately five minutes out from the hospital at that point. The baby was intubated with a 4.0 ET tube. That's just the size of the ET tube that I used, which was placed without difficulty. CO2 return was confirmed and --

Q. Is that the purple yellow thing?

A. Yes. And a chest x-ray was obtained for placement. At that point, the capillary blood glass is returned.

Q. Everything you have talked about, is that what you have documented there thus far?

A. Yes.

Q. Let's put up the rest of it.

A. And chest x-ray is obtained. At that point, the capillary blood gas result returned and showed a pH of 7.0 and a pCO2 of 64.

Q. Tell us what that means.

A. The pH we want to be ideally 7.4. That's the ideal acid based balance for all bodily functions to occur. That shows

that she is tipped a little bit more towards the acidotic, that's she's got more acidic in her blood than basic and she is not at the level that everything works well.

Q. What about the pCO2?

A. The pCO2 of 64 just means that she is not exchanging gas very well in her lungs for as hard as she was working. I would expect it to be lower if her lungs were working well and she was exchanging gas well.

Q. So what does that result are you -- what information does it give you at this point?

A. Well, it shows me that she's got what's called a respiratory acidosis. You have to have other, like her bicarb levels and things like that, to determine if there's a metabolic acidosis as well.

You can have metabolic reasons that throw off your acid base and you can have respiratory reasons to throw off your acid base balance. Hers, the majority of it was respiratory.

Q. Okay. So if you would go on.

A. The baby's perfusion was still not good at that point, and I ordered a 40 milliliter bolus of normal saline. We usually give ten milliliters per kilogram. Normal saline to be given at 9:35 a.m. and another one was given at approximately 9:45.

So the first bolus went in likely while I was bagging the baby and getting the intubation done, and then her perfusion still wasn't ideal, so I gave her a second bolus that was

infusing as the West Penn team arrived at 9:45.

Q. You go on to say --

A. The ampicillin had already infused at that point, and the gentamicin was started.

Q. You also say that maintenance IV fluid --

A. Maintenance IV fluid of D10W, which we start all of these babies on. D10 is the amount of sugar that's in the fluid and the W is just water. So we give them essentially sugar water, sterile sugar water. We don't put any electrolytes in it in the newborn period. Had been started at 12 milliliters per hour. That's calculated based on their weight as well.

I usually have my residents start it at 80 milligrams per kilogram per day and we can go up or we can go down. You have to manage their -- you don't want to overload them with fluid, but you want to give them enough to keep their blood sugar up.

Accuchecks, which are for the blood sugar, at this point had been 130 at 9:05 a.m. Those are done by heel stick by the nurses.

The initial chest x-ray for tube placement showed that the tube was slightly low, although we were getting very coarse breath sounds at that time.

So when we put a tube in, we listen to both sides because it's very easy to put it in too far and it goes off to the right, so we are really only inflating the right lung. So we listen to make sure we hear breath sounds on both sides, which

I did, but on the chest x-ray, it was a little bit lower than we like to see it, so we pulled back just a little bit so it's an ideal spot so it inflates both lungs really well.

The ET tube was retracted slightly and taped. We tape it into place so it doesn't move, and another chest x-ray was obtained to verify placement. The O2 sats continued to remain in the 70s, and the baby was very difficult to ventilate because of the noncompliant lungs and required high pressures to ventilate. That just meant that I really had to squeeze the bag hard to get the air into her lungs.

Q. I want to stop you at this point because there's another note that you made. Does that summarize everything you've told us up until this point?

A. Yes, and a little bit further.

Q. Let me just show the jury another note. This is page 1117, and I think this is your handwritten note that you made sometime around 9:00, and if you could just explain to the jury what that is.

A. That's just a note that I was jotting down. The dictation that I made obviously was after the fact. I jotted down some notes to say what I was doing, what was going on, because, like, we have to have something in the chart for the West Penn team to have to take with them, and they grabbed the chart and make copies of it for the team to take with them, so I was jotting down my findings and my plan as quickly as I could.

Q. That dictated note, that would have been typed up at some time later; is that correct?
A. Yes.
Q. So that wouldn't have been available for the West Penn team?
A. No.
Q. So if you would just tell the jury what you put in your note, and before you start, I want to ask you another question. This note is timed at 9:00 a.m., correct?
A. Yes.
Q. And that would have been -- was that the first time you had a moment to jot a note?
A. I think that I had something that was timed 8:20. I think it was the actual like the newborn assessment they do because they want that filled out, too, my initial assessment and then what she looked like at discharge, so I wrote that down because that has to go with the chart as well.
Q. So let's take a look at that one first and we'll come back to that. That's 1115. That's the same document, and is that your newborn assessment in the middle?
A. Yes.
Q. Can we highlight, because I think the categories we wouldn't be able to see them. This would have been the first one you did --
A. Yes, at 8:30. My assessment at 8:30.

Q. Your assessment is already done. You've done all of that. Now you are going to sit down and write this?
A. Write it down, yes.
Q. Okay. So tell us what your assessment was at that time?
A. The general appearance, the GFR means grunting, flaring and retracting. That MEE is not my handwriting. I think the resident has started to write, because their job is to actually do this for us, and then I co-sign it. I think the intern or resident had started writing the note and I directed them to do other things.

So MEE, that stands for molding. I don't use that abbreviation, but it stands for molding and edema. That's the scalp, the description of the baby's head.

And then eyes, ENT and thorax were insignificant at this point. The lungs were coarse. The heart was regular without murmur.

Q. When you say coarse, is that breath sounds?
A. Yeah, like crackly breath sounds.
Q. Okay.
A. Then, like I said, the rest of it was not pertinent to what I was doing at that point.
Q. So just so we are clear, it appears the resident started, and you told them, stop, I'll do it?
A. I think the resident had started writing it and then was actually going to do some other things, so they never finished

that note.
Q. Dr. Heiple testified that he didn't have a note because you were doing it, was that correct?
A. Right.
Q. Let's go back then to the other note that we started to look at. That one was first and this one was next, and if you can explain to the jury what you've documented there?
A. The date and time, the HVP stands for Heritage Valley Pediatrics. Three-hour old infant born to a 19-year-old G1P1, which is how many babies, how many pregnancies, delivered by vacuum.
Do you want me to read the abbreviations and what the words stand for?
Q. Yes, the words.
A. Vacuum vaginal with meconium. Birth weight 8-7. GFR tachypnea. Then the physical exam, AFOF, anterior fontanelle is open and flat.
Q. And what does that mean?
A. That just means their soft spot is open. Lungs, coarse; heart, regular without murmur; abdomen soft; full pulses. Assessment, meconium aspiration. Plan, CBC, blood cultures, CBG which is the cap gas, chest x-ray, start IV and amp and gent. Spoke with Dr. Leneri at West Penn and transfer. That's my signature.
Q. I want to ask you about your assessment. At that point

your assessment was meconium aspiration. Why?
A. Simply because that was in the history, and I was assuming that's what I was dealing with.
Q. Then let's go back to that previous note and her summary at the end, that document we were reading and stopped.
Before I go on from there, I just want you to explain to the jury what you remember, and then we're going to look at the note about what you document. The West Penn team arrives. What happens then?
A. She was very difficult to bag, meaning ventilate with the bag. Her perfusion was not good and we could not get her saturations up. They were staying low, and at that point, we had Dr. Leneri on the phone telling him step by step what was going on, and he was giving us orders of what to do.
West Penn travels with their own medications and equipment, and he suggested at that point that we give the baby surfactant to try to open up the airways since her compliance was so low.
So we gave the surfactant. The way you do that, -- it's a milky white substance. It almost looks like skim milk. They dose it based on the baby's weight, and you have to have an endotracheal tube in place to give it. We put it into the endotracheal tube.
We are essentially putting several milliliters of liquid into the baby's lungs which sounds crazy but this is -- it's a

medication that -- it's a substance that should be in there that we're just adding to help.

When we do it, we have to keep bagging, and it goes down and comes back up and goes down and comes back up, and we keep bagging until it doesn't come back up, which means it's been dispersed within the airways.

Q. Once the West Penn team came, did they take over?

A. Pretty much. I mean, I was there helping, but Dr. Leneri was telling us everything that we needed to do at that point.

Q. And was Jamie still there helping?

A. Oh, yes.

Q. And then in addition to you and Jamie, the transport team was also there?

A. Yes.

Q. So there were a number of folks there all working?

A. Yes. There were several people there, several nurses. Everybody was -- we would say we need this, we need this. There were people getting things and grabbing everything we needed.

Q. One of the things that was said yesterday was that the reason why you wanted to transport Kendall up to West Penn was -- I think I heard that there wasn't the appropriate equipment or you didn't have the equipment at Heritage Valley. Is that the case?

A. Well, we can't -- I mean, at that point, we didn't have a

ventilator. We can't ventilate babies. I transport them when we are not able to manage them there.

If she were to get worse -- like I said, she is on 64 percent oxygen. She could get better in an hour or she could get a lot worse, and I'm not going to stand there and wait for a baby to see if they are going to get better or worse. If they are on 64 percent oxygen, I would much rather transport a sick relatively stable baby than try to stabilize the baby that is getting sicker and scramble to get them stabilized so we can get them out and transfer them.

Q. That brings up another question. We heard about various levels of nursery. What level nursery does Heritage Valley have?

A. Well, we're a level one nursery and we do have level two capabilities. We call it a high risk nursery. We keep babies that are on a little bit of oxygen, have that TTN that I was talking about, have mild respiratory distress. Sometimes if the baby comes in, they are working a little bit to breathe, we've done this whole sepsis workup on them, started them on antibiotics, they are breathing a little bit fast but need a little bit of oxygen but are not to the point where they need to have what we call CPAP or intubation, we'll keep them. We'll keep babies that just need antibiotics. We'll keep babies that aren't feeding really well.

We actually will keep babies that have to be what we call

NG fed, where they are not eating or they have been sick and getting better but not eating well. We have to put a tube into their stomach that we put in through their nose so we can inject the formula into their belly if they are not able to eat well. We'll keep them for that, because the level of care they require, we can handle. We like to keep them if -- because it's better for mom.

Mom lives in Beaver and she's delivered there. If mom is still in the hospital, and we are capable of taking care of the baby, we would rather not separate mom and the baby if we don't have to.

Q. We've heard a term NICU.

A. Yes.

Q. I'm assuming that stands for neonatal intensive care unit?

A. Yes.

Q. Does Heritage Valley Beaver have a neonatal intensive care unit?

A. No.

Q. Is that why you wanted her transferred to West Penn because they do?

A. Yes.

Q. Let's pick up. You were starting to tell us about the transport team was there. You've now given the surfactant. What happens next?

A. We gave the surfactant. Her saturations were still low.

Her lungs were not compliant. We were still having a lot of trouble ventilating her.

When I say "ventilating," I mean, making her lungs work to keep her oxygen saturations up. At that point, they did have nitric oxide there.

Q. What is nitric oxide?

A. That is a gas that's normally produced in the lungs shortly after birth that actually helps dilate those pulmonary blood vessels. The blood vessels I was talking about when they are in utero are very tight and have high pressure. That nitric oxide is released into those airways, and that actually stimulates those blood vessels to dilate and we'll actually mix that with the oxygen that we are giving the baby so that we're trying to get those blood vessels to dilate to carry the oxygen away from the lungs.

Q. I want to stop you because I want to ask you another thing that I neglected to ask you. Before you intubated Kendall, did you go talk with Matt and Carissa again?

A. Not before.

Q. It was after?

A. Yes. Once I had intubated her, the West Penn team was there, we talked to Dr. Leneri and they do their assessments and start getting their equipment out and looking at her and getting her ready to go.

At that point, because I had put the tube down, I ran down

the hallway to just let them know that I had put the tube down and that the team was here, and we always take the babies down to see mom before we fly them out, and I ran down the hallway, went into the room and I said I just want you to know I had to put a tube down to help her breathe. The team is here. We are still working on her. We will bring her down as soon as we are ready to get her out of here so you can see her.

Q. So back now -- after you did that, you came back, and what you have been describing about the nitric oxide, was that after that?

A. Yes. It was after that.

Q. Okay. So now you've given the nitric oxide. Did that help improve the situation?

A. No.

Q. I didn't ask you. The surfactant, did that help improve the situation at all?

A. No.

Q. What did that tell you? The --

A. At that point, I was like why isn't any of this working? I mean, I was like this doesn't make any sense. None of this is working. Why can't we ventilate this baby?

Q. So the nitric oxide, the surfactant. What happens next?

A. I think at that point was when the monitor suddenly showed that her heart rate was very, very fast, and we looked up at it, and I remember I looked at the West Penn nurse, and I said

that can't be right, and got my stethoscope out and listened, and her heart rate had actually dropped into the 60s, at which point we started chest compressions, because anything under 80, we have to do chest compressions on.

Q. And what happened after the chest compressions?

A. Well, when you start doing the chest compressions, you are going to give epinephrine, which is essentially adrenaline to try to stimulate their heart to beat better. We gave her epinephrine several times, and there's different ways to give it, through the IV, down the ET tube. If you don't have an IV available, we put it in the endotracheal tube and bag it in there. We did both with her.

Q. Here's again your notes, if that helps you at all. I think approximately 10:50 that you were just talking about, heart rate on the monitor?

A. Yeah. At approximately 10:50, the heart rate on the monitor was noted to suddenly rise into the 200s and auscultation, that just means listening to her heart with my stethoscope, showed that her heart rate had dropped into the 60s. Chest compressions were started at that point and IV epinephrine was given by the West Penn team times two, so we gave it twice.

At that point, also during the ventilation, while we're bagging her, blood started coming back up out of the tube.

Q. What is the significance of that?

A. Pulmonary hemorrhage, that for some reason, she started bleeding, and we were getting bright red blood that was coming up into the ET tube and going up and down.

Q. We heard the term before DIC?

A. Yes.

Q. Is that what that was?

A. It very well could have been. DIC, disseminated intravascular coagulation, again, with gram negative sepsis, something that happens is that the platelets and another clotting factor in the blood called fibrin start to deposit in the tiny blood vessels in the body which causes clots and cuts off blood flow to certain organs, which is part of the reason that you end up with multisystem organ failure with DIC.

But the other thing that it does, because the liver is not functioning properly, and your liver is responsible for creating your clotting factors, there's a lot of different factors that make your blood clot, and those get used up very quickly when all of this clotting is going on, and then your body loses its ability to even form the clots and you actually start bleeding from everywhere and hemorrhaging.

And whether that was because of this or whether that was because of just the horrible inflammation that was going on in her lungs, I don't know but we were getting -- she had clearly had a pulmonary hemorrhage.

Q. And what you described for us, is that consistent with --

you told us about the E. coli being a gram negative sepsis. Is that what you see with a gram negative sepsis?

A. The DIC?

Q. This entire pattern that we've just gone through.

A. Yes. You can, yes.

Q. So you were telling us at that point there's pulmonary hemorrhage. What happens next?

A. We gave the epinephrine down the ET tube, because another thing that epinephrine does, it causes blood vessels to constrict. So we were trying to control the hemorrhage by putting the epinephrine down the endotracheal tube and bagging it in there to try to control the bleeding that was going on there, at the advice of Dr. Leneri again.

At that point, a spontaneous heart rate in the 120s was obtained, so her heart was beating on its own again in the 120s, but the saturations, her oxygen saturation remained in the low 60s to low 70s and then began dropping again.

We placed a second IV in her at this point. At that point, the heart rate began to drop again, well below 60, and we started doing chest compressions again.

We got another chest x-ray at that point to make sure we weren't dealing with a pneumothorax at this point, because again, a pneumothorax can cause what's called a tension pneumothorax where the one side fills up with air and pushes the heart off to the side and compresses it and the heart

can't beat effectively, and we can treat that by putting a needle into the chest to let all that air out, but there was no pneumothorax on that chest x-ray.

Q. At some point in time, did Dr. Leneri decide to end the resuscitation efforts? Are you okay?

A. Yeah. We gave her several more doses of epi, epinephrine, and kept doing the compressions for 25 minutes. It was a long time, and they were on the phone with him, and he told them to -- that he wanted to talk to me, and I went over.

At that point, the nurses and the respiratory therapist were doing the bagging and the chest compressions, and he told me, he said, listen, he said, you guys have been working on her for how long now. You've done this, you've done this, you've done this. This baby cannot be saved. She has been hypoxic for how long now and her brain was going to be so affected that we weren't going to be able to get anything back and we couldn't continue and to stop, so I told them to stop.

Q. After you told them to stop, did you then go and talk to the family?

A. Not right away, we stopped, and I went into the dictation room and shut the door and I cried, and I pulled myself together because I needed to go talk to them, and the West Penn nurse was there and --

Q. Let me stop you there for a second. Had you ever had anything like this happen to you before?

A. No.
Q. This is the first time?
A. Yeah.
Q. Is this the only time this has ever happened?
A. Yes.
Q. So you said the West Penn nurse was with you?
A. The West Penn nurse was with me, and she said do you want me to go talk to the parents, and I said no, I'm going to go talk to the parents, and she offered to come with me. So we walked down the hallway, and at that point, I know that there were more people in Matt and Carissa's room, and I don't remember.

I think I asked them if I could talk to them, if they wanted me to talk to them in front of everybody or if I wanted to send people out, and I honestly don't remember if people left or if they kept people in there, and I sat down on the bed. I think Jamie -- I don't think Jamie went with us.

I think her maternity nurse came with us as well.
Q. Would that be Chelsea?
A. If that was who was taking care of her. Like I said, I usually grab the nurse that's taking care of them, and I sat down on the bed and I told her that Kendall had passed and that we tried everything that we could, but her little body couldn't take it and she was gone.
Q. And I'm assuming that when you were there, you were crying

with them?
A. Yeah.
Q. At that point in time, did you know what had happened?
A. No.
Q. Did you have --
A. No. No. It's like this happens, you do this. This happens, you do this. This happens, you do this, and we were do doing it, and you keep pulling things out of your box to keep doing things, and pretty much, you look into the box and there's nothing left in there to do, and it didn't make any sense. It did not make any sense.
Q. When you said it didn't make any sense, one of the things that you told us that you were thinking about before is that this could have been a meconium aspiration. What had happened, the course of this, did it make any sense to you thinking initially it was meconium aspiration?
A. Babies don't die acutely from meconium aspiration. I mean, you can have respiratory issues, you can develop pneumonia down the road, you can develop pulmonary hypertension down the road, but everything just went so quickly and it was just -- it was just -- I was just -- I didn't know what was happening. It didn't make any sense to me.

In my mind and what I was doing and what I was working with, nothing made sense.

Q. So you've talked with Matt and Carissa; is that correct?
A. Yes.
Q. And we heard something yesterday about being told that she didn't make it on to the helicopter. Is that what you said?
A. That's not what I said.
Q. What did you say?
A. What I told you. I said we did everything. Her little body could not take it and she was just too sick.
Q. At that point, do you have any conversations with anybody else? For example, any staff? Anybody else at that point?
A. At that point, I don't think anybody really said much of anything. We were all just in shock.
Q. And that was on the 14th, and we've seen the time of death being around 11:40 a.m. Did you have any conversations with Dr. Heiple that day?
A. I don't remember if I talked to him or not. I don't think I did.
Q. Did there come a time where you received -- before we get there, we've heard and we've seen that an autopsy was done here. Was it done that day or was it the day after?
A. I think it was -- it wasn't done that day. It was probably the day after.
Q. Do you have a recollection of going to talk with Dr. Min?
A. Yes.
Q. Can you tell the jury about that conversation?

A. Dr. Min called me and said, you know, I'm going to do this autopsy on this baby. Can you come down and give me a clinical history of what happened so that I can kind of know what I'm looking for here to look at.

MR. PRICE: Objection, Your Honor. At this point, I believe this is all hearsay.

THE COURT: Sustained.

Q. I don't want you to tell the jury what was said, but if you can just give the jury an understanding of what happened.

A. I went to Dr. Min's office and -- his assistant was there, and Dr. Min and I went over what I just went over with you, essentially what happened, the history and all the resuscitative efforts and all the medications and everything that we did.

Q. Did you tell him at that time that you thought this might be a meconium aspiration?

A. Well, I told him, I said, I don't know what's going on. I said the baby had meconium. I said, if this was meconium aspiration, I said I can't explain why she -- why we couldn't resuscitate her.

Q. Was that the only conversation you ever had with Dr. Min?

A. Yes.

Q. Did you at some point learn the results of the blood culture you had ordered and the tissue cultures?

A. The blood culture, I believe, because all of these labs go

to our office and somebody reads them and signs off on them, even the ones for the inpatients, and I think Dr. Scibilia's name -- was the admitting doctor, so it went to him, and I remember he called me and he said, hey, did you know that your baby's blood grew E. coli, and I said no, I didn't. He said, yeah, your baby had E. coli sepsis, and it was kind of like, oh, my God! That's why it wasn't going to work. That's why nothing worked.

Q. And does the E. coli sepsis then explain the entire series of events that we've talked about here today?

A. Yes. At that point, it made sense, that she had an overwhelming E. coli sepsis, and I want to say -- it wasn't an aha moment. It was, oh, my gosh, it makes sense. This is why I couldn't resuscitate her.

Q. In terms of why that makes sense, is this what you see with an overwhelming E. coli sepsis?

MR. PRICE: Objection, Your Honor. Leading.

THE COURT: Sustained.

Q. What do you see with an overwhelming E. coli sepsis?

A. Just that they're extremely sick and a lot of them -- it has a very high mortality rate. A lot of them do not survive.

Q. And in this particular case, do you think anything would have changed the course here?

A. Not in her case, no.

Q. Why is that?

A. Because I think it started long before she was -- not long -- it started before she was born. She had that infection and she was born and was transitioning and her little body did the best it could but couldn't do any more.

Q. After Kendall had passed on the 13th and the jury has seen the death certificates. You did two of them; is that correct?

A. Yes. They wanted me to fill one out immediately, and I didn't even know where I was supposed to go to do it. I had to go to medical records and fill it out.

Q. Had you ever done one before?

A. No.

Q. So we saw the first one which listed a variety of different things and then there was a second one. Why did you do a second one?

A. I'm not exactly sure. They sent me a second one because the diagnosis at that point had changed, because we had the E. coli blood culture results and I guess the autopsy results and I just remember that the funeral home called me, and they actually sent a representative to the office because they were trying to plan the funeral, and they didn't want to delay anything so they sent somebody to my office for me to sign the revised one.

Q. Now that you've got the E. coli sepsis culture result back, what did Kendall die of?

A. She died of overwhelming E. coli sepsis and pneumonia.

Q. Did meconium have anything to do with that?
A. I don't know if the meconium had anything to do with that or not, but she had E. coli sepsis.
Q. Now, we've heard some testimony about a meeting that you and Dr. Dumpe had with Carissa and Matt. First and foremost, do you remember when that occurred?
A. I don't remember when it occurred, no.
Q. Are we talking about weeks or less than a month?
A. Honestly, I can't -- it wasn't months, but I can't tell you exactly how long it was.
Q. Whose idea was it to have that meeting?
A. I spoke with Dr. Leneri, because I actually called him to let him know what the blood culture results were and to fill him in on everything that went on and why this -- we got the result that we got, and when I talked to him, he said --
Q. You can't say what he said. You can talk about your understanding.
A. It was my understanding that in cases like this, because a lot of times the parents have a lot of questions, and in order to help them get closure, to talk to them and explain to them what was going on and answer any questions, and especially in mom's case, alleviate any guilt she might feel about anything she could have done or she should have done differently.
Q. Did you then have some conversation with Dr. Dumpe?
A. I spoke with Dr. Dumpe and he said -- well, because he had

a relationship with Carissa. I really didn't. The only contact I had with her was that day, so I suggested that he call and set up the meeting.

Q. And that happened?

A. Yes.

Q. Can you tell us what you can recall about that meeting?

A. It was in Dr. Dumpe's office which was on the same level as the nursery. It was in the hospital on that level, and Dr. Dumpe and I was there and the nurse supervisor, and her name escapes me, there was a nurse supervisor who was there as well and Carissa and Matt and then somebody's mother or aunt was there. There was one other family member, I believe.

Q. Okay. So can you tell us then what happened at this meeting?

A. Dr. Dumpe did most of the talking. We just essentially explained to them that your baby grew E. coli out of her blood. She had an overwhelming infection, and that that was why she passed, and I remember Carissa asked something about -- I don't recall exactly, but from the conversation, that she was thinking that this was something that she did, and I remember just reassuring her that it wasn't anything that she could have done differently, that there wasn't anything that she did wrong.

And I do remember talking to her about meconium at delivery, because -- and I do remember telling her about my

first daughter having meconium at delivery as well, and some babies do totally fine and some babies have issues with it, but that the meconium -- I don't think the meconium was the problem. It was the E. coli sepsis.

Q. And do you remember if Matt and Carissa had any questions for you or Dr. Dumpe?

A. I think they asked a couple of questions, but it was overwhelming for them at that point. I don't remember a whole lot of what was going on. I don't remember a whole lot from that meeting.

Q. Was it the situation that any questions that they asked, either you or Dr. Dumpe made an effort to answer for them?

A. I'm sorry. Repeat that.

Q. Sure. Any questions that they asked, is it the situation that you attempted to give them answers?

A. Yes.

Q. Same thing with Dr. Dumpe?

A. Yes.

Q. After that occurred, did you have any additional contact with Matt and Carissa before you came to the courtroom here today?

A. No.

MS. KOCZAN: Thank you. I think those are all the questions I have for you.

THE COURT: Thank you, Ms. Koczan. Mr. Colville.

CROSS-EXAMINATION

BY MR. COLVILLE:

Q. Good afternoon, Doctor. My name is Michael Colville and I represent the United States in this case.

When you met with Carissa and Matt with Dr. Dumpe, it was your opinion at that time that -- you told them that the meconium was not the problem in this case. I'm sorry. The meconium was not the problem in this case. It was the E. coli?

A. Yes. The E. coli sepsis was what killed their daughter.

Q. When you were talking about the E. coli sepsis originally with Ms. Koczan, you mentioned the high mortality rate.

One of the questions that she asked you subsequent to that was would anything have changed the outcome, and I believe your answer at that point was no; is that right?

A. No, I don't think anything would have changed.

Q. The next question was -- or one of the statements was that you believe that the E. coli sepsis started or the E. coli infection had started before the baby was born?

A. Yes.

Q. Would you having been present at the delivery, would that have changed the outcome in this case?

A. Not based on what needed to be done. We don't treat -- we treat based on symptoms.

Q. In this case, you've reviewed the medical record; is that

right?
A. Yes.
Q. You've seen the delivery assessment?
A. Yes.
Q. You've seen Dr. Dumpe's operative report; is that right?
A. Yes.
Q. Do you believe that you should have been called at the time of delivery in this case?
A. I wouldn't have been -- at that point, no. It didn't seem like anything else needed to be done. With thin meconium, the resuscitative efforts are fairly minimal.
Q. Were there any resuscitative --
A. Other than bulb suctioning the mouth and throat, it doesn't sound like they needed to do anything for her.
Q. And are the nurses who did that certified in that specialty?
A. Yes.
Q. Was Dr. Dumpe certified in that as well?
A. Yes.
Q. That's something you were certified to do as well?
A. Yes.
Q. Is that the idea of calling a pediatrician to be present at the delivery in the presence of meconium so that, in your case, the pediatrician could be there in case resuscitation needs to occur?

A. Yes, in case resuscitation needs to occur, and in the case of particulate thick meconium, that the deep tracheal suctioning can be done.

Q. In this case, was the deep particulate meconium present?

A. No.

Q. Dr. Karotkin identified a number of potential concerns he had or that he believed warranted you being called to be there at the delivery. You were here for that testimony; is that correct?

A. Yes.

Q. Did any of Dr. Karotkin's concerns prove to be problematic during and after the delivery?

A. His concerns?

Q. Were there any consequences of his concerns that showed themselves after the baby was born?

A. Not until she was in the nursery.

Q. Were there any issues that, you as a pediatrician being present, would have addressed at delivery?

A. No.

Q. Can we pull up Exhibit 6, page 10? We've seen this document a number of times. This is the delivery assessment. Based on the results of this delivery assessment, is it accurate to say that the baby that was delivered by Dr. Dumpe was a healthy baby?

A. Yes.

Q. In an otherwise healthy baby who has meconium present, how do you manage the meconium?
A. Well, depending on the degree, the quality of the meconium, and again, the NRP guidelines have changed with this, but at the time you suction the mouth and nose so that, when that baby takes her first gasping breath, that that doesn't get inhaled into the trachea and into the lungs.
Q. Was that done in this case?
A. Yes.
Q. By Dr. Dumpe?
A. Yes. Ideally, before the baby actually comes out and is stimulated, you want to suction that stuff out of their mouth and throat so that when they take that first breath, there's nothing that is going in there.
Q. And as Dr. Dumpe's op report indicated, that's what he did?
A. Yes.
Q. Was there subsequent suctioning as well?
A. Yes.
Q. If you had been there at the time, would anything else -- would anything differently had been done that wasn't done the day Kendall was delivered?
A. No, because --
MR. PRICE: I'm going to have to object. This is speculation. She wasn't there. She can't evaluate this baby.

THE COURT: Sustained.

Q. Based upon the delivery assessment that you see in front of you, do you believe you would have needed to do anything differently that has been documented as having been done on the day of the delivery?

A. Well, with the Apgar of one at the one minute with the respirations means she was breathing at that point, and we don't do the deep tracheal suctioning and all of that when they are breathing. Once they are breathing, we oxygenate them.

Q. Would there be any reason to prescribe antibiotics at this point?

A. No.

Q. Why not?

A. Because she wasn't in any distress, and we don't routinely treat prophylactically for the possibility of meconium aspiration.

Q. Do you treat in anticipation of a possible infection?

A. No.

Q. Without symptoms?

A. No.

Q. So in this case, with this delivery assessment, was there any reason anyone looking at it should have been thinking that there's a possibility that there's an E. coli infection in play here?

A. No.
Q. How about any infection?
A. No.
Q. So if you wouldn't have prescribed antibiotics at the delivery and you wouldn't have resuscitated beyond what was done by Dr. Dumpe and the nursing staff, if you had been called, what would you have done at that point? Would you have stayed around?
MR. PRICE: Objection. Speculation.
THE COURT: Sustained.
Q. What is your experience when you are called?
A. Go ahead.
Q. When you are called to attend a delivery such as this, once there are no symptoms present, there's no need for an antibiotic or resuscitation, what do you do?
MR. PRICE: Objection, Your Honor. Can we define this type of delivery?
THE COURT: Right. He used the words "such as this." Rephrase, Mr. Colville.
Q. Delivery evidenced by this delivery assessment. If you were called to this delivery and you did not need to resuscitate and you did not need to provide antibiotics, what would you do as the attending pediatrician?
A. If I come to a delivery and there's no -- nothing for me to do, then I take a look at the baby and if it has good

Apgars, I would say call me if you need me and leave.
Q. Would you wait then? Once you left, would you wait here for symptoms before you acted on anything?
A. Wait and hear for symptoms --
Q. In this case, the delivery assessment shows no symptoms to act upon or to cause you to prescribe an antibiotic.
A. Yeah. I would wait. I mean, if symptoms developed, then you start antibiotics and the workup.
Q. Is it fair to say you don't do anything until symptoms show up?
A. Yes. We don't give anything until symptoms show up.
Q. You mentioned the surfactant that was administered. Can you explain to me again how that process worked?
A. It's -- I believe it comes in a bottle, and they calculate the amount to give based on the baby's weight, and you have to have an endotracheal tube in place to give it, and we squirt is into the endotracheal tube with a syringe, small amounts at a time, and force the air -- bag the baby and force it into the lungs and it comes back up, and force it in again, and keep doing it until it doesn't come back anymore.
Q. Can you see the liquid going in and out?
A. Yes.
Q. You described it as milky?
A. Yes. It looks like skim milk.
Q. The liquid is going down in the tube that you've intubated

the child with; is that right?
A. Yes.
Q. Go back to when you intubated to begin with. You are looking into the lungs at that point?
A. I'm looking into the trachea.
Q. Can you see into the lungs at all?
A. Not into the lungs.
Q. You can see into the trachea?
A. Yes.
Q. And if a baby had been aspirating meconium, would it be located in the trachea?
A. If there were a lot of meconium, I would see it in the trachea, and you can actually see sometimes it will stain the vocal cords as well.
Q. When you did intubate that day and -- is it the ringer scope?
A. The laryngoscope.
Q. When you applied that, were you able to see into the trachea clearly?
A. Yes.
Q. Were you able to see whether or not there was any meconium?
A. I did not see any meconium at that point, no.
Q. Did you see any meconium staining?
A. No.

Q. If you had, would that be an indication there was a significant amount of meconium in the lungs or there was some meconium in the lungs?
A. It would tell me that there had been meconium at that level, yes, and if it were past the cords into the trachea, yes, definitely.
Q. Going back to when you administered the surfactant, once you put the liquid in and you say it goes up and down, and that's because you are using the bag?
A. Yes.
Q. How long a process is that?
A. It takes a couple of minutes.
Q. Were you actually physically doing it at that point?
A. I -- I don't believe I was bagging. I think the West Penn nurse was doing the bagging, but I was standing right there.
Q. Were you present and could see?
A. Yes.
Q. Could you see the liquid going up and down?
A. Yes.
Q. During that period of time, does -- if there is meconium in the lungs, does it mix with the surfactant?
A. If there were a lot of it, yes.
Q. Would it change -- is it your experience as it went up and down, that the surfactant color would change as a result of it being mixed with the meconium?

A. If it were mixing with the meconium, yes.
Q. Did you see any change in the color of the surfactant while they were bagging in this case?
A. No. It stayed milky.
Q. Dr. Karotkin described the meconium and E. coli yesterday as two separate atomic bombs. Do you agree with that?
MR. PRICE: He didn't say that.
THE COURT: He did say it was atomic bomb 1 and atomic bomb 2.
MR. COLVILLE: I thought it was. One of plaintiffs' experts described it as two atomic bombs.
Q. Do you agree with that?
A. Do I agree it's two atomic bombs?
Q. Yes. He equated the meconium and E. coli --
A. In this case?
Q. Yes, in this case.
A. In this case, no. I would say that the E. coli was an atomic bomb, and the meconium was probably more like a firecracker.
Q. In the face of this delivery assessment, should Dr. Dumpe have reached out to you?
A. With this assessment?
Q. Yes.
A. It doesn't look like I was needed.
Q. Was this a healthy baby?

A. Yes.

MR. COLVILLE: Thank you.

THE COURT: Ladies and gentlemen of the jury, it's time to take our afternoon break. So at this point, once again, if you'll leave your notebooks and your exhibit binders there on your chairs and we'll take a 15 minute break.

I know our court reporter has worked particularly hard. We've all learned a lot of medicine this afternoon, so once again, keep all of this information in your head. Don't discuss. Don't research. Don't communicate. Enjoy this break. Mr. Galovich.

(Jury excused.)

THE COURT: Doctor, you may step down. Mr. Galovich is going to check with our jurors to see if any of them have any plans that are taking them out of town for this Labor Day weekend and how much longer they can stay, whether it's until 3:00, 3:30, 4:00, 4:30. We'll see what they have to say.

THE CLERK: They said no problem staying to the normal time today. Two of them were worried is this going to go beyond next week. I said that's parameters the judge gave you, because two of them the week after have prepaid vacations. That's the parameters the judge gave you. I'll remind the judge. That's fine.

THE COURT: So we can go until about 4:30 if we need to today. Since that ate up about ten minutes of your break

time, you can still have break until 3:10.

MS. KOCZAN: Can I make a request? Can we be done at 4:30? I have an event I have to attend.

THE COURT: I understand that. I think this particular juror here will want to be done at 4:30 for her bus. She did say that. So we will conclude no matter what at 4:30.

(Recess taken.)

(Jury present.)

THE COURT: Dr. Jones has retaken the stand. We are going to have cross-examination by Mr. Price. We understand everybody wants to wrap up today at 4:30. Mr. Galovich had to leave for a family matter, so Mr. Kravetz, who is my career clerk, is taking over for him.

CROSS-EXAMINATION

BY MR. PRICE:

Q. Good afternoon, Dr. Jones. As has been stated, plaintiffs had made no allegations against you with regard to the care that you gave to Carissa after 8:20 a.m.

Do you understand that?

A. Yes.

Q. And the allegation that is against you is based upon medical records in the Heritage Valley Beaver medical file which claim that you were called at 7:20 in the morning.

Do you understand that?

A. Yes.
Q. Now, before I get into that issue, I just wanted to talk to you about a lot of the issues you talked about treating Kendall and treating patients like Kendall.
Now, whenever you came into the hospital, you did not know what was going on with regard to Kendall, so in a situation like that, when you look at her, the first thing you noticed was that she was in respiratory distress, correct?
A. Correct.
Q. And whenever you have a patient in respiratory distress, you, as a doctor, don't know what is causing that respiratory distress, because you mentioned it could be a variety of things, correct?
A. Correct.
Q. And you can't say, okay, I'm just going to address one thing because you might miss another thing. So basically, you have to take a global approach, correct?
A. Correct.
Q. And the first thing you do is you give oxygen to the baby to help it breathe, right?
A. To increase the oxygen saturation.
Q. Right. It's able to breathe. You want to make sure more oxygen is getting into the body.
The second thing you mentioned was that you suspect that it's some type of infection so you give antibiotics, correct?

A. Correct.
Q. So in this case, and in most cases, the standard antibiotics are the ampicillin and gentamicin, correct?
A. Yes.
Q. So if you were called at 5:30 in the morning and they said, hey, we have a baby with meconium, grunting, flaring, retracting, in pain, had substernal retractions, you would order oxygen and antibiotics, correct?
A. If they were to call me at 5:20 and say that this is the case, I would likely call the resident and say did you look at this baby, and I'm coming in to take a look at the baby as well.
Q. And after you came in, the first orders, if you saw a baby like that, in that type of respiratory distress, you would give oxygen and antibiotics, correct?
A. In what type of respiratory distress?
Q. Grunting, flaring and retracting, low pulse ox.
A. Essentially the way Kendall was when I first saw her?
Q. Yes.
A. Yes, I would do what I did.
Q. The sooner the E. coli is treated with antibiotics, the better the result is, correct?
A. The sooner the E. coli --
Q. I just want to see if you still agree with this. The sooner you treat any neonatal sepsis, including E. coli, the

better?
A. Yes.
Q. Now, sorry to jump around here, so if I understand the relationship with Kendall, while she had this E. coli neonatal sepsis, that was what you had to treat, but underlying that was -- what made it so difficult was the meconium aspiration. That made it more difficult to resuscitate her with the compliance of her lungs and the ability to ventilate her, correct?
A. If she had -- yes. If she had meconium in there, it would make it more difficult, yes.
Q. Right, because that's what we talked about in your deposition. You said the neonatal sepsis was really what made her so sick. The meconium aspiration made it more difficult to resuscitate her with the compliance of her lungs and the ability to ventilate her.
A. Yeah.
Q. You said that?
A. Yes.
Q. Now, let me ask you about when you arrived. You mentioned that when you came in, there were two babies in the nursery who were in bad shape. One being Kendall and the other one that had this anomaly, right?
A. I wouldn't say the other one was in bad shape. It needed to be transferred and further evaluated.

Q. At the time that you got to the hospital though, that second baby, you said, was stable?
A. Yes.
Q. However, just so we understand, and again, we're not going to get into the condition of the second baby, but I think you said he had a birth anomaly that could potentially deteriorate quickly.
A. It could have underlying issues.
Q. So while -- I mean, you were still concerned about that baby while caring for Kendall?
A. Concerned about the baby?
Q. Yes.
A. The state of the baby?
Q. I don't know what the condition of the baby was. I'm not allowed to find that out.
A. I was concerned enough to transfer the baby.
Q. Okay. Now, you come in and whenever you came in -- well, let me back up again. Again, I'm sorry I'm moving around here. It's the way things came in to my mind.
Ms. Koczan asked you that, when you were driving in, if Dr. Heiple had called you and told you what his examination revealed, you had no need to rush into the hospital. Do you remember saying that?
MS. KOCZAN: Objection. That wasn't her testimony.
MR. PRICE: That was your question.

THE COURT: Sustained. I think you need to rephrase.

MR. PRICE: Sure.

Q. The question that was asked of you was that if you were driving into the hospital and Dr. Heiple -- because the residents call you sometimes, correct?

A. Yes.

Q. And if he told you what his examination findings were from his examination findings, there would be no need for you to rush in?

MS. KOCZAN: Objection. That was not her testimony.

THE COURT: That's not exactly what she said.

Q. Let me ask you it this way, because my concern was that if you had received a call from Nurse McCrory at 7:50 stating that I have a patient who has an 81 percent oxygen rate who is grunting, flaring and retracting in pain with substernal muscle use, abdominal muscle use to breathe, would that be something that would get your concern?

A. Hypothetically? Because that's not anything that happened.

Q. Right.

A. If they had called me and said I had this baby, I would have said where is the resident, and asked the resident to evaluate the baby, and let me know what he thought.

Q. Okay. Whenever Nurse McCrory put Kendall on oxygen, she put her on at 64 percent, correct?

A. Yes.
Q. And you mentioned that you usually don't see babies with more than 40 percent oxygen?
A. I said I don't keep babies that are needing more than 40 percent oxygen to maintain their saturations.
Q. Keep. So 64 is something outside of what your nursery usually uses?
A. It's more than I like to keep them.
Q. In a situation like that, a nurse like Nurse McCrory is supposed to call her supervisor, correct?
A. I don't know what their protocol is.
Q. The supervisor in this case was Janet Kincade. Do you know Janet?
A. No.
Q. We'll pull up tab 6, page 10, and we've all seen this document. I'm sorry, not 10. It's 11. I'm sorry.
This is the -- here's what I want to concentrate on. This part down here (indicating).
So you are the physician, Dr. Jones, and this is in the -- you are taking care of the baby, correct?
A. Yes.
Q. And Nurse McCrory is there as well as Peggy and Janet Kincade, who is the supervisor, right?
A. That's what it says.
Q. And the recorder, the person who was to record the time

and everything, is Janet Kincade, the nurse, right?
A. That's what it says.
Q. Let me see the whole document. She is there during all this in the nursery recording what's going on. You don't remember her?
A. No, I don't.
Q. If we could go back to page 10, and again, I'm sorry. Whenever you were answering Ms. Koczan's questions, you said that whenever you first came to the nursery and you evaluated Kendall, that all you really noticed that she was maybe grunting a little bit.
A. That's not what I said.
Q. What did you say?
A. I said she was working a little bit to breathe and she was on a lot of oxygen.
Q. Let me get my notes. You said that she was retracting, working to breathe, but you don't recall flaring.
A. I don't recall flaring.
Q. But let's block out this. Go all the way down. That's your assessment at 8:30, correct?
A. Correct.
Q. And whenever you put GFR, that means grunting, flaring and retracting, correct?
A. Correct.
Q. And then if you could go to page 15, and this is the note

we've seen all about, but I just want the top part. It just says right here: Upon my arrival in the nursery, but was still grunting, flaring and retracting. I know you said head is wrong and coarse lung sounds.

So just to confirm, whenever you got there, Kendall was grunting, flaring and retracting and had coarse lung sounds?

A. When I got there, she was not grunting yet. This, I dictated a long time after everything was done, and I mean, she started grunting, yes, shortly after that, but when I first arrived in the nursery, she was not grunting.

Q. But your first assessment, you noted at 8:30 that she was grunting, flaring and retracting?

A. At 8:30, yes.

Q. If we could pull up No. 22 and I think it's No. 51. I just wanted to ask you about this. I mean, they showed you this picture about the -- let's get the word out -- alveoli that's got pneumonia in it, correct?

A. Yes.

Q. And then on the right side is the picture you saw and it's the same type of lung sac, and it could have meconium in it, correct?

A. On the left side?

Q. Correct.

A. That's the picture demonstrating the meconium in the alveoli, yes.

Q. And so it could basically be either meconium or pneumonia, which is what the report was, correct?
A. What report?
Q. The autopsy report.
A. That it could be.
Q. There was meconium and there was some signs of pneumonia.
A. On the autopsy report?
Q. Right.
A. Yes.
Q. Exactly. You can take that down. If you could pull up tab 8 and highlight this part. Now, so this is the first death certificate that you filled out, correct?
A. Correct.
Q. And it says, and we read this yesterday, enter the chain of events that directly caused the death, and you said that you had to go to the medical records department because you had never filled one of these out before, right?
A. Correct.
Q. And whenever you did that, the first thing you put was meconium aspiration which occurred at 5:20 a.m., correct?
A. That's not the first thing. That's the last thing.
Q. I know. I'm going timewise. Interval onset to death. So that was actually the first thing that happened in the sequence of events which led to her death, correct?
A. The information that I had at that point, yes.

Q. And that's because, if there was any meconium aspiration, it would have occurred before she was born, correct? You can't get meconium aspiration after you are born.

A. That's when you get meconium aspiration. You don't get meconium aspiration until you take your first breath.

Q. Right. At the time of birth.

A. You said before she was born.

Q. Right. You breathe it in utero?

A. No. Babies don't breathe in utero.

Q. I'm sorry. I'm not using the medical terminology breathe. They ingest it?

A. They can swallow it. They can get it in their mouth, but babies -- in utero, babies will make some breathing movements, but they are not really like breathing stuff in and out. The lungs are small. There's fetal lung fluid in there, but they are not breathing in utero. They make some movements, and in labor, chemicals are actually released that suppress those breathing movements that they have.

Now, if a baby becomes anoxic in utero, where the oxygen is severely depleted for some reason because the placenta is not working or the cord is compressed, they can make some gasping movements in utero.

Q. You were right. I used the wrong medical terminology. I'm not a doctor. What I meant to express is the only way Kendall got meconium was in utero?

A. When you say "got meconium," it was --
Q. As you know, upon the autopsy, it said that meconium -- that Kendall had massive aspiration of meconium, correct?
A. That's what the autopsy shows, yes.
Q. That's what the autopsy showed. And my point is, the only way that she could have gotten that was through ingesting it in utero?
A. When you say "ingesting," that means swallowing.
Q. Swallowing in utero. How do you want to put it?
A. If she was swallowing, it's going to go into her esophagus and her stomach.
Q. Okay. Well, how do you get meconium into your lungs?
A. If it's in the back of your throat or in your mouth when you are born and it's not removed from your throat and your mouth, then when you take that first breath, they can get it into their trachea and into their lungs.
Q. So when Kendall was being born, she had meconium in the back of her throat and breathed and got it down deep into her lungs, correct?
That's the only way you can have, on autopsy, a massive aspiration of meconium is what you just described. She took in a whole gulp of meconium down into her lungs, correct?
A. If that's what they found, she had to have inhaled some meconium probably from the back of her throat.
Q. Right. Now, you also noted at 9:00 pulmonary

hypertension. At 10:55, pulmonary hemorrhage and at 10:50, the cardiac arrest, correct?

A. Yes.

Q. Now, can we go to the second page of that tab, and this is the second death certificate. I showed the top of it in the opening, but I want to show the bottom part because this is the one you talked about that you had to change. They asked you to fill out a second one. This is the official one.

And it says enter the chain of events that directly caused the death, and you left the immediate cause was meconium aspiration, correct?

A. That's what it says.

Q. And then it says sequentially, those conditions leading to the cause or it's an underlying cause was the neonatal sepsis, correct?

A. Yes, she had neonatal sepsis.

Q. At the time you were filling it out, you still believed that meconium aspiration was the immediate cause of Kendall's death, correct?

A. Based on the autopsy findings.

Q. Right. Now, I'm going to jump back to the time that you were at the hospital. Now, you get there and you noticed, and I know the time is disputed, if it's 8:00, 8:20, like Dr. Heiple says, you are there after 8:00, and you see Kendall and you start issuing orders, correct?

A. Yes.
Q. Now, from my understanding, you gave verbal orders and then the doctors would write those orders in, correct?
A. Yes.
Q. And from what I understand with Kendall's condition, you ordered all of the orders to be stat, correct?
A. They are always stat.
Q. They are always stat. If we could pull up page 47 of tab 6, and if we could have this part. Now, let's see.
We start out with Dr. Heiple at 8:32 enters the order for ampicillin, correct?
A. Yes.
Q. Now, he also enters an order at 8:32 for a blood gas.
Do you see that?
A. Yes.
Q. Now, below that one, I see the word "stat."
A. Yes.
Q. Under the ampicillin, I don't see stat. Do you?
A. No.
Q. And if we continue down, the next one was the chest x-ray at 8:32, and he ordered that one stat, correct?
A. Yes.
Q. And can we continue on to -- I don't know if it's the next page. Keep going down. A CBC and differential at 8:32, he ordered that stat, correct?

A. Yes.
Q. If we go on the next page, 48. At the top, again, at 8:32, blood culture, he ordered that stat, correct?
A. Correct.
Q. Another blood culture at 8:32 by Dr. Heiple stat, and then we go down to the gentamicin, and he ordered that at 8:32, but again, I don't see any stat order on the gentamicin, do you?
A. I don't know if they put a routine stat on the medications. They are given as soon as we get them.
Q. And that was the whole discussion about this bullet tube coming up and everybody getting the medications as quickly as you can, correct?
A. What was?
Q. I mean, on direct, you talked about the drugs coming up from the pharmacy through a bullet tube?
A. Yes.
Q. Now, if we take a look at page 25 of tab 6, and these are the -- just the whole thing. These are when the drugs were given, and from what I can see, the ampicillin, it was performed at 9:40.
Now, I know that you talked about the ampicillin being a drug that has to be given over a half hour, correct?
A. Yes.
Q. So it may have begun at 9:10 and was finished at 9:40?
A. I don't remember. There was a note that was other than

this that was saying when the ampicillin was being administered.

Q. Right. We're going to get to that in a minute, but I'm just trying to draw the timeline again for the jury so we all understand.

So if ampicillin takes a half hour to finish, if it was performed at 9:40, it would be given at 9:10, correct?

A. I'm sorry. Say that again.

Q. Sure. If the ampicillin was finished being done at 9:40 and if you say it takes a half hour to give, that means it was started at 9:10 a.m.?

A. If that were the case, yes.

Q. I'll show you my facts in a minute to confirm that because it comes from your note. And then after that was finished, the gentamicin was given, correct?

A. Correct.

Q. And that wasn't given until 9:50, correct?

A. Where are you seeing?

Q. At the very bottom.

A. Yes.

Q. 9:50. And the reason why, I mean, that was unfortunately one hour and 50 minutes before Kendall's death, correct?

A. Yes.

Q. And as you mentioned, I know that antibiotics take some time to take effect, and probably at that point, giving

gentamicin would have had little to no effect on Kendall, correct?

A. At that point?

Q. At 9:50.

A. Antibiotics take hours to take effect.

Q. Now, if we could -- page 8 of tab 6. Here is where I just want to confirm all these times. Let's say right in the middle, because this is from your note where you say, the West Penn -- the baby's perfusion was still not that good. A bolus was given at 7:35.

THE COURT: It says 9:45. If he's following the pointer, it says 9:45. I think you said 7.

Q. Follow along with my pointer here. So the baby's perfusion was still not that good. You order another bolus to be given at 9:35. Another one is given at 9:45, just as the West Penn team was arriving.

The ampicillin had already infused at that point, so if they come at 9:45, and if you remember the last record, the ampicillin was performed at 9:40, so it had just finished up. Does that make sense?

A. That it just finished up, yes.

Q. And then you continue on. At that point, you are referring to 9:45, the gentamicin was started?

A. Yes.

Q. So the gentamicin, like I said, it wasn't started until

9:45, 9:50 in the morning, correct?
A. Correct.
Q. And the earlier you treat an infection, the better chance you have for treating that infection, correct?
A. Correct.
Q. Now, if we could pull up page 30 of tab 6 and highlight this area. Now, you've seen this record, of course, and this is the record that was authored by Janet Kincade, the nursing supervisor.
And just so I understand, you don't get to be a nursing supervisor unless you work for a long time, right?
A. I have no idea how you get to be a nursing supervisor.
Q. But nursing supervisors are the people that nurses call. It's sort of up the chain of command. They call their supervisor to come in and help them out, correct?
A. They do the administrative work.
Q. Now, what we're saying is -- you are saying that that record there, Dr. Jones notified at 7:20 is inaccurate?
A. It is inaccurate.
Q. So that is an inaccurate medical record?
A. It is.
Q. If we could go to page 10 of tab 6 -- scratch that.
I wanted to go to -- before we get to that tab 15, and tab 15, the jury hasn't seen yet, but this is an incident report, and this incident report is what? After an event like this

where something goes wrong in a hospital, somebody reports it to administration because you have to have an after event --

MS. KOCZAN: Objection to the form of the question.

THE COURT: Sustained.

Q. Do you know what an incident report is?

A. It's a report about an incident.

Q. Okay. Why do you file incident reports?

A. There could be any number of reasons to file them.

Q. Can you tell us some?

A. No. I mean, I don't know when you would file incident reports. That's not my scope.

Q. So you've never filed an incident report?

A. No.

Q. Then I won't explain why it happened, but these are notes that again Janet Kincade wrote on the 13th, and if you could just highlight the first two sentences. Infant born at 5:20. To nursery around 6:30.

While in nursery, infant started having respiratory distress. Residents notified, along with Dr. Jones, regarding infant in nursery with respiratory distress.

Then it says at 7:20 oxy hood and lab work with IV placement completed. So from that record, it looks like before 7:20, you were contacted?

A. That's what it looks like.

Q. Is that accurate?

A. No.
Q. Now, if we could pull up document 10, and we've seen this record, the Apgars and the examination. I don't want you to pull anything out, but I just want you to agree with me, how do we know that everything on this record is accurate?
A. I don't know.
Q. You'll agree with me there can be inaccuracies in medical records?
A. There can be.
Q. And you'll agree with me that sometimes people's descriptions of things in medical records can likewise be inaccurate?
A. Descriptions of -- as far as like descriptions of an exam or we're talking about writing down times that things happen?
Q. Right. An examination of kids, the Apgars, there can be inaccuracies, couldn't there?
A. It depends on who is evaluating the patient.
Q. Depending upon what nurse supervisor Janet Kincade did and what she wrote, that's the reason why you are here, right?
A. Because she wrote down that I was notified at 7:20.
Q. Right.
A. Yes.
Q. Now, you mentioned that whenever you came into the -- this was your word -- that it was more a crisis situation in the nursery whenever you got there.

A. It was a situation that required a lot of attention, yes.
Q. Let me ask you this: If you had been there to evaluate Kendall at, let's say, 6:30, you would have no idea what her situation was, right? There's no way for us to tell what her situation was?
A. I don't know what she looked like at 6:30.
Q. If you were present at birth and noticed that there was some respiratory distress and if you had noticed that Kendall needed to be watched a little bit more closely, and I think your answer to Mr. Colville was I would take a look at the baby and wait. If you did that, and you noticed that she had some respiratory distress, you would continue to follow her, correct?
A. Yes.
Q. And if you continued to follow her, would there be a chance that you would have picked up on the respiratory distress earlier than when you got there at 8:20 in the morning?
A. It depends on when she presents with the respiratory distress.
Q. Is there a chance that if you were there earlier, that you would have had a chance to evaluate Kendall to determine if she had respiratory distress?
A. I have no idea. I don't know what she looked like.
Q. Right. The point is though that it wasn't until you came

in at 8:20 that Kendall was diagnosed with respiratory distress, correct?

A. No. The nurse found she had some respiratory distress shortly after she came to the nursery.

Q. But you were the first doctor on board at 8:20?

A. Not at 8:20.

Q. Well, depends on the records. Depends on who you believe, because I don't know if all of your records are accurate at this point, but the point is that if you were there earlier and you saw that Kendall -- let's take even an hour earlier.

If you were there at 7:20 and you had noticed the grunting, flaring and retracting, 81 percent, would you have started her on oxygen and done a neonatal sepsis workup?

A. I would have done what Nurse McCrory did. She put her on oxygen and we probably -- it's hard to say because I don't know what she looked like.

When I saw her, she was working a little bit, and like I said, her oxygen requirement was high. This happens -- babies do this a lot. They'll have some respiratory distress. They'll have some oxygen requirement and sometimes it's just transitioning and sometimes it's worse.

Generally, there's a rule of thumb. If baby is still requiring supplemental oxygen two hours after delivery, then we start to think is this just transitioning or is this something else.

Q. This wasn't transitioning?
A. No, this wasn't transitioning.
Q. Right. But do you believe that, and I know that, like I said, the antibiotics didn't get to her, at least the gentamicin, which was sensitive to E. coli, didn't get to her until 9:50 in the morning.
Do you believe if you had been there earlier and if you had given her antibiotics earlier, that there was at least a chance?
A. I don't think it would have made a difference in her case.
MR. PRICE: Okay. That's all the questions I have.
THE COURT: Ms. Koczan, any follow-up?
MS. KOCZAN: Just a couple.

REDIRECT EXAMINATION

BY MS. KOCZAN:
Q. Doctor, you were asked some hypothetical -- not hypothetical, but questions about what if at 5:20, she was grunting, flaring and retracting, et cetera.
Is there any evidence in this chart that she was grunting, flaring and retracting at 5:20?
A. No.
Q. Is there any evidence in this chart that there was anything going on before 7:25 a.m.?
A. No.
Q. And even assuming, and I just want to make sure I

understood your last response, even assuming at 7:25, somehow antibiotics got started, would that have made any difference here?

A. I don't think it would have.

Q. Why is that?

A. She had an overwhelming sepsis that had already started and was already taking over. She had used up all of her white blood cells. They were gone. They were fighting infection, and at this point, she had nothing left to fight the infection with.

MS. KOCZAN: Thank you. That's all.

THE COURT: Mr. Colville, anything else of this witness?

MR. COLVILLE: No questions.

THE COURT: Doctor, I just have a couple of questions.

Looking at one of these Heritage Valley Beaver records, I think it was one of the last ones that Mr. Price put up. It's marked at the bottom Exhibit E. At the top of the page, it says the attending physician is James P. Scibilia. You previously advised us that he's one of your colleagues, right?

THE WITNESS: Yes.

THE COURT: So to that end, if by chance, the nurse called thinking James Scibilia is involved and he's really

not, you are the one on call, how does the message get to you?

THE WITNESS: That doesn't happen like that. The reason that we have the different attendings, there's several people in our group, and every week, they list a different physician as the attending, but there's a specific call schedule, and whoever is on call, they will call.

They don't look at -- Dr. Scibilia is listed as the attending on a lot of babies. They don't look at who the attending is. They see it's Heritage Valley Peeds. They don't say this is Dr. Scibilia's baby. They say this is HVP's baby, and they call whoever is on call for us.

THE COURT: How does Heritage Valley Peeds alert the nurses as to who is on call?

THE WITNESS: I believe they have a copy of our schedule and the hospital has a copy of the schedule.

THE COURT: So it would be up to the nurses to have a copy of that at their station, right?

THE WITNESS: Either at their station or the hospital operator always knows who is on call.

THE COURT: Now, this call schedule, does it include the office number or just the cell numbers?

THE WITNESS: They have our cell numbers if they need them for an emergency. Otherwise, they call -- they either call the operator and have the operator call our Cortext line or they have our emergency line. The emergency line rings to

the Cortext operator, our paging company.

THE COURT: Do you know from your experience in this hospital, do the operators keep records of who they call when?

THE WITNESS: I don't know if they keep records or not.

THE COURT: As far as the records that have been produced on this issue, those are your records, right, your pager records and your cell records?

THE WITNESS: They were our practice Cortext records.

THE COURT: So it's your practice Cortext records which I was calling pager records, right?

THE WITNESS: Yes.

THE COURT: And then they are your cell records?

THE WITNESS: That was my cell phone, correct.

THE COURT: And were you asked to check in your office to see if there was any record vis-a-vis calls as it relates to Kendall?

THE WITNESS: Our office?

THE COURT: Right.

THE WITNESS: Our office wasn't open when she was --

THE COURT: I understand that, but sometimes pediatricians have a call in number.

THE WITNESS: Yeah, our emergency line, but it would have gone straight to our paging system.

THE COURT: So the emergency line goes straight to

the paging system?

THE WITNESS: Yes.

THE COURT: Now, another question I have is -- I think I'll save that for somebody else.

Another question I have is, as you know, some policies of the hospital have been entered into the record, and to that end, some of these policies reflect your signature. One being administration of oxygen for newborns and the other one being -- there's a second one, I think that also references you, but I don't think I have it, but generally, how do these policies develop?

THE WITNESS: The director of the department and the nursing supervisors put them together is my understanding. I'm not involved in putting policies together.

THE COURT: You have not been involved yourself?

THE WITNESS: No.

THE COURT: Even though one of these policies references you as Hilary Jones, M.D., Chairman Pediatric Department Beaver?

THE WITNESS: Because at the time I was the chairman of the department, and our duties with that are to attend the pediatric department meeting and read off the minutes and essentially run the meeting, and then we have to attend the med exec meetings and just be present, and we have to sign whatever they give us to sign as the chairman of the

department.

THE COURT: At the time I think of this particular policy I'm looking at, where you signed, Vida Kaniecki, M.D. was the chairman of the pediatric department at Sewickley. You were at Beaver, and James Scibilia was medical director nursery department Beaver, right?

THE WITNESS: Correct. He's always the department director.

THE COURT: Would he be the most involved vis-a-vis these policies?

THE WITNESS: Yes.

THE COURT: These policies are updated from time to time; is that right?

THE WITNESS: I believe so.

THE COURT: Then they are circulated around. Is that what happens?

THE WITNESS: As far as --

THE COURT: Because there are a number of signatures with different dates.

THE WITNESS: Yeah, because the different chairs and different people have to sign them.

THE COURT: Okay. So the other policy I was looking for is 2.21, notification of pediatrician/nursery for expected delivery of potentially high risk infant. This one also contains your signature on 11-20-14. Do you recall that?

THE WITNESS: I don't recall. I mean --

THE COURT: Be that as it may, it would be the same process?

THE WITNESS: Yes.

THE COURT: So it would be largely Dr. Scibilia?

THE WITNESS: Yes.

THE COURT: And whoever this head nurse is?

THE WITNESS: Yes.

THE COURT: This policy notification of pediatrician/nursery for expected delivery of potentially high risk infant was signed off by Dr. Dumpe on 11-18-14, by you on 11-20-14, by Dr. Scibilia on 11-21-14, but there's a prior policy that had been in effect in August of 2009, it would appear. Do you recall that?

THE WITNESS: I would have to look at it. I don't know.

THE COURT: Now, when these policies are handed down, is there any kind of an in-service or something that alerts practitioners to the fact that the policy is there and/or it's been changed?

THE WITNESS: If it's been changed.

THE COURT: Who runs those?

THE WITNESS: Runs the in-services?

THE COURT: Right.

THE WITNESS: They would be discussed at our

pediatric department meeting.

THE COURT: One other question. The residents, do they sleep overnight, or do they live in the neighborhood?

THE WITNESS: They stay at the hospital.

THE COURT: They stay at the hospital. They have a call room?

THE WITNESS: Yes.

THE COURT: So Dr. Heiple would have been there overnight?

THE WITNESS: I don't know who was on call overnight. He was on for pediatrics that day.

THE COURT: He had been at the lecture. That's what he said.

THE WITNESS: Yes. They start very early.

THE COURT: Now, does the court's questioning cause anybody to have some additional questions?

MR. PRICE: Not upon your questioning. However, I'd like to follow up on Ms. Koczan's.

THE COURT: Okay. Mr. Price, what else?

RECROSS-EXAMINATION

BY MR. PRICE:

Q. If Kendall's death was solely caused by E. coli, then why do you care whether or not she had massive aspiration of meconium?

A. Why do I care?

Q. The whole defense, why did Dr. Dumpe go down to see Dr. Min except for to say this wasn't massive aspiration of meconium?

A. I didn't go down to see Dr. Min.

Q. Pardon me?

A. I don't know why you are asking why do I care.

Q. Your defense, part of it, if you were called at 7:20, the defense was this wasn't massive aspiration of meconium.

My point is, if this death was solely from E. coli, whether or not she had massive aspiration of meconium, who cares? It's all E. coli.

A. I'm not saying who cares. I'm saying what killed Kendall was her overwhelming E. coli sepsis.

Q. That's your opinion, and my point is that also on this autopsy report is massive aspiration of meconium, and the defense is got to get rid of that. My point is why?

MS. KOCZAN: Objection, Your Honor. The defense --

THE COURT: Sustained.

MS. KOCZAN: That's objectionable.

THE COURT: You could rephrase that, Mr. Price, if you want to attempt to do that.

MR. PRICE: I'll try.

Q. I guess basically, if you are basically saying this is just a case of E. coli, whether she had little massive aspiration, it wouldn't matter, right?

A. If she had a little bit of meconium, if she had a lot of meconium, I don't think it would have mattered. She had overwhelming E. coli sepsis. She had pneumonia, and I believe that she was going into DIC towards the end of the resuscitation.

Q. I know you had it very tough once you started working on her, but I just don't understand why we're fighting over massive aspiration of meconium if it doesn't matter?

MS. KOCZAN: Objection, Your Honor.

MR. COLVILLE: Objection, Your Honor.

THE COURT: We'll save that for argument.

Ms. Koczan, anything further?

MS. KOCZAN: Just one question.

REDIRECT EXAMINATION

BY MS. KOCZAN:

Q. Doctor, you were asked some questions by the court about the policy 2.21, and if we could put up 434. I think that's the last page of that policy. Up at the top there, in the -- where it says origination date reviewed and then revised.

According to this record, was the last time this policy was revised was August of '09?

A. Correct.

Q. One other thing I wanted to ask you about this policy. So this signing off of it wasn't revising anything?

A. No.

Q. The last time it had been revised was August of '09. One other thing I want to show you about that and ask you about that. 433, which is the page before that.

Underneath where it says all this, procedures, and there's references I just want to ask you, could you highlight the references?

Is this an indication that this policy was based upon these various things, the ACOG practice bulletin, the American Academy of Pediatric Guidelines, et cetera?

A. Yes.

MS. KOCZAN: Thank you. That's all.

THE COURT: Anything else, Mr. Colville?

MR. COLVILLE: No.

THE COURT: Mr. Price?

MR. PRICE: No.

THE COURT: Dr. Jones, at last you may step down, and I don't know that we have another witness lined up for now; is that correct?

MS. KOCZAN: That is correct, Your Honor.

THE COURT: And it also is 4:00. So ladies and gentlemen of the jury, as we've done repeatedly, we're going to have you put your binders and pads there on your chair. Instead of Mr. Galovich, you are going to have Mr. Kravetz who will take custody of those and lock them up in our exhibit room over the Labor Day holiday.

As I've told you over and over again, don't discuss this case with anyone, including fellow jurors, other people involved in the trial, members of your family at the cookouts that you'll all be attending this weekend or anyone else.

Again, do not speak to the parties coming or going. Do not speak to any of these other folks that have been coming in watching the trial as you come or go. You have Mr. Galovich's cell phone number just in case you need it over the weekend and he'll be happy to return anybody's call if by chance you get sick or there's some other issue he needs to know about.

Once again, I don't know if there is or isn't any news coverage, and to that end, you should not watch or listen to any news coverage that might pertain to this case. Likewise, you should not do any research over this three-day break, and that would include even informal research, talking to a family member or friend who might be a nurse saying what do you think about this, you should not do that, because the only information you are to consider is the evidence you see and hear in this courtroom, and then ultimately, you'll be listening to the closing arguments and my instructions.

Continue to keep open minds. You have been very diligent this week. You've taken in a lot of information. I've seen a number of you taking copious notes and paying very deep attention. The court appreciates it, as do the litigants

and the parties.

So with that, Mr. Kravetz is going to escort you out. I don't know what all your personal plans are, but if one or more of you have plans that you are going to be out of town and you are concerned about getting here on Tuesday morning, if you would let Mr. Kravetz know that so that in case somebody is coming in late, say, Monday night and they want to start at 9:30 or 10:00 rather than 9:00, he's going to ask you that when you go back in your room.

Have a good weekend and safe travels. Enjoy the holiday.

(Jury excused.)

THE COURT: Okay. So what will the lineup be on Tuesday?

MS. KOCZAN: I didn't know if Mr. Colville wanted to take this.

THE COURT: I know what he wants to do. I've already told these jurors that, in effect, out of courtesy, Mr. Colville is letting you go ahead, and I just think, from the standpoint of presentation, whatever you are going to do vis-a-vis these lay witnesses, we should get done, and then I know he's got the doctor coming in to testify on behalf of Dr. Dumpe, and if he needs to call back Dr. Dumpe, I think that works better as a block rather than in and out.

MR. COLVILLE: Actually, what I was going to tell you

is we've decided not to do it that way. I think Paula is going to call Dr. Dumpe.

THE COURT: Okay. However you want to call it.

MR. COLVILLE: Dr. Wiesenfeld will be here in the morning.

THE COURT: So what time do you expect him here?

MR. COLVILLE: I told him to be here at 8:30, but if Ms. Koczan wants to continue on, he can follow or --

THE COURT: So he's made himself available all day? Magee is letting him come down all day? Take him away from his gynecological research in herpes? Go ahead.

MR. COLVILLE: He's ready to go first thing in the morning.

THE COURT: Okay. That would probably be preferable to him so he could go back to the UPMC Mercy or Magee, right?

MR. COLVILLE: Sure.

THE COURT: So he should be ready to go right out of box at 9:00. How long do you anticipate he's going to be?

MR. COLVILLE: No more than an hour.

THE COURT: On your end.

MR. COLVILLE: I'm not even sure an hour on my end.

THE COURT: Then, of course, he has to be crossed.

Then, Ms. Koczan, who all do you still have?

MS. KOCZAN: I have Barb Hackney. I'm going to call Janet Kincade.

THE COURT: You got her?

MS. KOCZAN: I got her. So she is coming in.

THE COURT: Live from Arizona. She got a free trip home.

MS. KOCZAN: I don't know that she necessarily views it that way, but she is coming.

THE COURT: Well, she got a free trip home to Pittsburgh courtesy of Heritage Valley.

MS. KOCZAN: I have Barb, Janet and I may call Dr. Dumpe and then I have my expert, Dr. Boyd.

THE COURT: Right. Mr. Kravetz, have you polled everybody?

THE CLERK: They are all good at 9:00.

THE COURT: Tell them that's when we will start, because the first doctor can be here at 9:00 ready to go. That's going to be a pretty full Tuesday, right? Then what, if anything, do we have on Wednesday?

MS. KOCZAN: Wednesday, I have my two final experts, Dr. Coffin and Dr. Ringer, and I think I'm probably going to try to have them both here at the same time, so as soon as we are done with one, the other one will go on.

THE COURT: Once again, the court has a meeting over the lunch hour, so I'm going to be out of commission between noon and 1:15, and as you know, we have to adjourn on Wednesday at about 2:45 for Magistrate Judge Dodge's swearing

in ceremony.

MR. COLVILLE: Is that Tuesday or Wednesday?

THE COURT: That's Wednesday, so you were trying to pack in both of your experts. I'm not sure that's going to happen. Depends. We're going to start at 9:00 with them and then we'll go to 12:00, we'll break, 1:15 and we'll go to 2:45. That's Wednesday. And hopefully they both get done. Otherwise, somebody is going to be staying overnight.

And then on Thursday who, if anybody else, do we have?

MS. KOCZAN: We don't, Your Honor, not from our perspective.

THE COURT: How about you, Mr. Colville?

MR. COLVILLE: No.

THE COURT: At this point, Mr. Price, do you anticipate any rebuttal?

MR. PRICE: Not at this point.

THE COURT: At some point, and it's probably going to be Thursday, we're going to need the charge conference. So what we might do on Thursday is do the charge conference first thing in the morning and tell the jurors they can come in a little bit later. So depending on how that all goes, we might be able to have closings on Thursday afternoon.

Now, I have an 8:30 criminal matter on Wednesday that I'm going to have to attend to before I start with you all at

9:00 on Wednesday, and vis-a-vis the charge, you have what I call a discussion draft. You could make things move a lot quicker if you start looking at that and e-mail back to Nicole comments so we can start working on that.

Now, I guess I'm jumping the gun here. Are we going to have another Rule 50 motion?

MS. KOCZAN: Yes, Your Honor. Actually probably two of them.

THE COURT: So one will be vis-a-vis Dr. Jones again?

MS. KOCZAN: Correct.

THE COURT: And the other one is going to be on corporate negligence?

MS. KOCZAN: Correct.

THE COURT: So we're going to have to make rulings. I guess that might be Thursday morning and the charge conference might be Thursday afternoon, so you might be making closings Friday.

If you are going to bring these motions again vis-a-vis Jones and if you are going to bring me a new one on corporate negligence, the sooner I get it in writing the better so we can work on it on our end.

MS. KOCZAN: I think the corporate negligence, I wanted to wait until plaintiff rested. They've done that today so I'll have that to you -- I'll try to see if I can have that filed tonight, or Mike is working on that.

THE COURT: I figured that.

MS. KOCZAN: I'm here. He's there.

THE COURT: Mr. Hamilton, the trustee, is doing all the research and writing. As soon as you get that filed, that will be helpful. Do you anticipate a written response to the corporate negligence motion or not? Depends on what it is. The corporate negligence claim is only against the hospital. It's not against the pediatric group, although the pediatric group is named.

MS. KOCZAN: It's just against the hospital.

THE COURT: I'm glad now we know what to look forward to.

Mr. Price?

MR. PRICE: I do not understand why Dr. Dumpe is going to be called again as a witness.

THE COURT: Well, I guess we can have a proffer.

MS. KOCZAN: To talk about -- there was testimony from Dr. Karotkin yesterday who talked about these policies and how they are developed and whether they meet the standards, and Dr. Dumpe was on the committee for this.

THE COURT: He previously testified, how did he say it, something about one of the nurses wrote them and they came by and he looked at them and signed them. It wasn't too in depth, let's put it that way.

So given the court's inquiry, I'm sure you all want

to bolster that. Go ahead.

MR. PRICE: Why would he be allowed to be called back when he already answered the questions about how the policies were? Just to rebut what my experts say?

MS. KOCZAN: Your Honor, he's entitled to do that.

THE COURT: Number one, he's entitled.

Number two, he's being called, if you will, in a different guise. He's now being called vis-a-vis the corporate negligence claim against the hospital is the way I see it.

MS. KOCZAN: That is correct.

MR. PRICE: Well --

MR. COLVILLE: Your Honor, I also would like to clear up the issue regarding the deposition transcript that you mentioned last night, and that was what I intended to address here this afternoon, and we pulled back once Paula indicated she was going to move forward.

MR. PRICE: We're going to have another whole testimony from Dr. Dumpe. It's got to be limited, because all of a sudden, the door's open, and the problem is the jury hears -- if the jury wants to hear this issue about the policies to rebut Dr. Karotkin, that's fine, but this case could go on forever --

THE COURT: It's not going to go on forever. You should see my schedule the week of the 9th. I must have 20

criminals listed.

MR. PRICE: The other issue I have is I know that I filed a motion against cumulative expert testimony on two of the experts, but at this point now, we're getting worse because Dr. Jones is a pediatrician who has testified as an expert and --

THE COURT: No. She testified as a treating doctor, and all of you elicited opinions. She is allowed to give her opinions vis-a-vis the treatment.

MR. PRICE: I don't have a problem with that.

THE COURT: She did that and then some.

MR. PRICE: And I didn't say that I had a problem with that. My problem is how many times are we going to learn how to score an Apgar.

THE COURT: Hopefully, we're not going to learn that again.

MR. PRICE: How many times are we going to learn how to score the assessment at 7:20?

THE COURT: Once again, I think defense counsel would be shrewd to take a real hard look at what they need from these potential expert witnesses.

MR. PRICE: I disagree with that because I think this case is going to be boredom into submission for the jury.

THE COURT: I don't know. From all accounts, and I watch them very carefully, I think they are very engaged with

this.

MR. PRICE: Because I cannot envision, as Mr. Colville said --

THE COURT: They will also be rested up, fueled up. They will have had cookouts galore this weekend. They'll be ready to go on Tuesday.

MR. PRICE: If we have on Monday Dr. Wiesenfeld.

MS. KOCZAN: We won't. Monday is Labor Day.

MR. PRICE: Whatever.

THE COURT: Tuesday we're getting him, 9:00 in the morning.

MR. PRICE: Tuesday, Dr. Wiesenfeld. He's not going to be all morning unless Paula goes off for two hours which she can't because it's an obstetric case, nevertheless.

Barb Hackney, she was there for half an hour. Are we going to really get into everything she's ever done as a nurse like we did -- we spent an hour with Judith Ash on irrelevant stuff which I told the court was going to happen and it happened.

We talked about fetal strips and her heart rate all afternoon when that's not an issue in this case and --

THE COURT: As I heard the testimony, I think at least one of your experts indicated that he -- they were all hes -- might be concerned and we talked about category two and possibly two plus and three vis-a-vis those strips, so I

didn't think what she had to say was that troublesome.

MR. PRICE: My trouble is going to be when it comes to Wednesday, whenever we have another pediatrician and another pediatric infectious disease doctor.

THE COURT: You had a pediatric infectious disease doctor, and so the defendants are then entitled to rebut that.

MR. PRICE: I understand, but now they have another pediatrician. We've heard everything about neutrophils. We've heard --

THE COURT: Right. I'm cautioning everybody, as I've watched these jurors, they are taking notes, they are paying attention. Per Mr. Galovich, they are very engaged. They are copacetic. They are getting along well. I think they will be refreshed and renewed and ready to go on Tuesday.

You just heard from Mr. Kravetz, rather than start a little bit later given the holiday, they want to be back here at 9:00 in the morning.

MR. PRICE: From my perspective, it's to get it over and done with.

THE COURT: Maybe, maybe not. I go back to my CMU case. That went almost a month. Those jurors on December 26 wanted to come back at 8:30 in the morning and they brought their own doughnuts and they ended up providing a verdict of 1.2 billion, the biggest verdict this area has ever seen.

MR. PRICE: To move things along, Your Honor, I have

read all -- your charge. I'm fine with everything. I have no problem.

THE COURT: It may have to change based on rulings related to, query, is Dr. Jones going to be still in the case or not, is there going to be a corporate liability claim here or not. That's one issue.

MR. PRICE: My point is from everything I've read, I'm fine with it. If you have to take things out after your rulings, I don't have a problem.

THE COURT: I appreciate that. That makes my job a little bit easier. Ms. Koczan and Mr. Hamilton, who does all the research, they may have a different view. We'll do everything we can to expedite things.

As I said, I rearranged this schedule for two solid weeks, and I have criminals literally chomping at the bit to get in here for changes of plea, suppression hearings, supervised release hearings and sentencings. You've heard me say before, and your clients should know, too, we have the biggest number of criminal defendants this court has ever had.

I've got to do those, so that's why we have to get this done. I was supposed to have had another trial right after you, Mr. Wiley, but Mr. Wiley decided -- he thought he was going to plead out, but then when the government made the offer, it was a little too much for Mr. Wiley. So now he says he wants a trial again. Mr. Wiley is a little wily. He's

reset for trial in December.

Anything else for the good of the order? In terms of all of your materials and the like, I don't know if you want to leave them here over the weekend. We will be locking up here. There is a cleaning team that will come through. Sometimes on these long weekends, they come Friday night and they are not back in here again until Tuesday night, so I don't know what Goodwill, who is our clean team, are going to be doing here or not.

There are a lot of medical records here and the like, so I wouldn't just leave them every which way, given the fact that there will be a clean team here. They do not go into the jury room.

MS. KOCZAN: Can we leave things here?

THE COURT: You can, but as I said, I would just make sure everything is closed up and the like. Once you are all gone, Mr. Kravetz and Ms. Starr will lock everything up. We'll see you on Tuesday. Everybody have a good holiday weekend.

(At 4:21 p.m., the proceedings were adjourned.)

C E R T I F I C A T E

I, BARBARA METZ LEO, RMR, CRR, certify that the foregoing is a correct transcript from the record of proceedings in the above-entitled case.

\s\ Barbara Metz Leo 09/25/2019
BARBARA METZ LEO, RMR, CRR Date of Certification
Official Court Reporter

I N D E X